Provider Manual

Provider Experience Department: 1-855-242-0802

AetnaBetterHealth.com/Louisiana

Aetna Better Health® of Louisiana

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PROVIDER MANUAL REVISION LOG

Status (New or Addition)	Topic	Summary	Location	Effective Date
Addition	LA Medicaid Provider Enrollment	Added provider revalidation of enrollment requirements per IB 25-14	Chapter 4: Provider Enrollment	04/01/2025
Addition	Home Health Claims	Added MCO Manual language clarifiing EHH billing	Chapter 17: Encounters, Billing, and Claims	01/01/2025
New	Acadian ED Reduction Pilot	Introduction of Acadian Health ED Reduction Pilot Program	Chapter 5: Covered Services	02/10/2025
New	Provider Network Monitoring Program	Added details on Provider Network Monitoring Program for behavioral health providers	Chapter 7: Behavioral Health	01/01/2025
New	DME Provider Requirements	Added LDH requirements for DME providers	Chapter 4: Provider Enrollment	01/01/2025
New	DME Reimbursement	Added CMS standards for DME reimbursements	Chapter 17: Encounters, Billing, and Claims	01/01/2025
New	Disposable Incontinent Supplies	Added coverage details and criteria to align with approved policy AMA 7200.81	Chapter 5: Covered Services	02/10/2025
Addition	PBM Rebranding	Updated PBM information to Prime Therapeutics	Chapter 21: Pharmacy	10/01/2024
Addition	Enteral Nutrition and Infusion Pump	Added coverage details and criteria to align with approved policy AMA 7200.71	Chapter 5: Covered Services	12/15/2024
Addition	Home Health and Extended Home Health	Added coverage details and criteria to align with approved policy AMA 7200.72	Chapter 5: Covered Services	12/15/2024
New	Hospital Bed, Mattress, and Lift	Added coverage details and criteria to align with approved policy AMA 7200.73	Chapter 5: Covered Services	12/15/2024
Addition	Hospice	Added coverage details and criteria to align with approved policy AMA 7200.74	Chapter 5: Covered Services	12/15/2024
New	Supplemental Oxygen and Supplies	Added coverage details and criteria to align with approved policy AMA 7200.75	Chapter 5: Covered Services	12/15/2024
Addition	NEAT	Updated CAT form to align with IB 24-38 revision	Chapter 6: Medical Transportation	01/01/2025
Addition	Transcranial Magnetic Stimulation	Updated critera to align with IB 24-27 revision	Chapter 7: Behavioral Health	11/01/2024
New	Emergency Oxygen	Added Emergency Oxygen policy information to align with IB 24-41	Chapter 5: Covered Services	10/31/2024
New	Act 246 Implementation	Amends Schedule IV drugs to include Mifepristone and Misoprostol	Chapter 21: Pharmacy	10/01/2024
New	Disposable Infusion Pumps	Introduces coverage of disposable infusion pumps in accordance with IB 24-34	Chapter 5: Covered Services	09/01/2024
New	Respiratory Viral Panel Coverage	Adds coverafe of respiratory viral panels in accordance with IB 24-31	Chapter 5: Covered Services	09/01/2024
New	Expansion of Mental Health Professionals	Adds PLPCs, PLMFTs, and LMSWs as reimbursible provider types for certain services/procedures	Chapter 7: Behavioral Health	08/01/2024

Status (New or Addition)	Topic	Summary	Location	Effective Date
New	Transcranial Magnetic Stimulation	Adds coverage for TMS in accordance with LDH IB 24-27.	Chapter 7: Behavioral Health	08/01/2024
Addition	Medicaid Provider Portal	Introduce LDH process for newly contracted providers to enroll in the Medicaid Provider Portal	Chapter 4: Provider Enrollment	07/01/2024
Addition	Screening Mammography	Updated to align with LDH IB 24-18	Chapter 5: Covered Services	06/01/2024
Addition	Proprietary Laboratory Analyses	Updated to allow coverage in facility, observation and/or inpatient settings only in alignment with LDH IB 24-16	Chapter 5: Covered Services	05/01/2024
New	Corneal Collagen Cross-Linking	Added coverage to align with LDH IB 24-17	Chapter 5: Covered Services	05/01/2024
New	CPAP Devices	Detail criteria for the coverage of CPAP devices	Chapter 5: Covered Services	06/01/2024
New	CPT Vest-High Visibility Chest Wall Oscillation Devices	Detail criteria for the coverage of CPT Vest-High Visibility Chest Wall Oscillation Devices	Chapter 5: Covered Services	06/01/2024
Addition	Applied Behavior Analytics	Updated ABA requirements and language per LDH updated guidelines	Chapter 7: Behavioral Health	05/01/2024
Addition	EFT/ERA Enrollment	Updated EFT/ERA vendor info to ECHO	Chapter 17: Encounters, Billing, and Claims	02/01/2024
Addition	Administrative Denial	Added policy language that outlines process for requsting and appeal rights for administrative denials	Chapter 14: Prior Authorization	01/01/2024
New	Gender Affirming Care	PA requirements and limits to Gender Affirming Care and Newborn Circumcision	Chapter 5: Covered Services	01/01/2024
New	Theraputic Day Center	Included coverage details and PA requirements	Chapter 5: Covered Services	01/01/2024
Addition	Chiropractic In Lieu of Services	Update to Chiropractic In Lieu of Services Coverage age requirements	Chapter 5: Covered Services	01/01/2024
Addition	Home Health Services	Additon of EVV requirement for Home Health and PCS services	Chapter 5: Covered Services	01/01/2024
New	Substance Use Intensive Outpatient	Addition of SUIOP services and requirements	Chapter 5: Covered Services	01/01/2024
Addition	Prior Authorization	Clarified notification requirements for CPST, CSR, and Crisis Response	Chapter 14: Prior Authorization	01/01/2024
New	Social Determinants of Health	Details billing requirements for providers to receive SDoH incentive	Chapter 17: Encounters, Billing, and Claims	01/01/2024
New	Billing Corrected Claims	Detail process for billing of corrected claims	Chapter 17: Encounters, Billing, and Claims	01/01/2024
Addition	Provider Refunds	Detail process for submitting provider refunds	Chapter 17: Encounters, Billing, and Claims	01/01/2024
Addition	Medicaid Provider Enrollment Portal	Updated provider portal enrollment requirements to align with IB 22-38 and LDH memo on PECI edits 314 and 641.	Chapter 4: Provider Enrollment	06/30/2023

Status (New or Addition)	Topic	Summary	Location	Effective Date
New	Pediatric Day Healthcare Services	Addition of PDHC from policy A-LA 7100.34	Chapter 5: Covered Services	11/19/2019
Addition	Enrollee Reassignment	Update to enrollee reassignment eligibility to align with LDH update	Chapter 1: Introduction	10/18/2023
Addition	Anesthesia	Additional coverage for anesthesia for pain management to align with IB 23-13	Chapter 5: Covered Services	09/20/2023
New	Pharmacy Benefit Manager	New PBM Magellan and corresponding LDH policy changes added	Chapter 21: Pharmacy	10/28/2023
New	Diabetic Supplies as Pharmacy Benefit	Transferred coverage of certain diabetic supplies from DME to Pharmacy benefit to align with IB 23-11	Chapter 21: Pharmacy Management	10/01/2023
New	Rapid Whole Genome Sequencing	Added coverage for Rapid Whole Genome Sequencing of Critically Ill Infants to align with LDH update	Chapter 5: Covered Services	05/23/2023
Addition	ABA Telehealth Services	Added ABA telehealth coverage details to align with LDH's updated BH manual	Chapter 7: Behavioral Health	05/12/2023
New	Adult Dental Coverage	Added adult dental coverage for adults with developmental or intellectual disabilities in an ICF to align with Act 366 and IB 23-7	Chapter 5: Covered Services	05/01/2023
Addition	Behavioral Health Emergency Certificates	Added Emergency Certificate criteria for inpatient or residential behavioral health services	Chapter 7: Behavioral Health	01/01/2023
Addition	Portable Oxygen Content	Update to authorization requirements to align with LDH	Chapter 5: Covered Services	10/01/2022
New	In Lieu of Services	Addition of In Lieu of Services description to align with LDH	Chapter 5: Covered Services	03/01/2023
New	Behavioral Health Telehealth Services	Addition of behavioral health telehealth services to align with LDH update	Chapter 7: Behavioral Health	03/01/2023
Addition	Mental Health Intensive Outpatient	Update of MH IOP services coverage	Chapter 5: Covered Services	03/06/2023
Addition	Transportation	Update of emergency and non-emergency transportation to align with LDH and policy update	Chapter 6: Medical Transport	03/31/2023
Addition	Additional Services	Update of Value Added Benefits to align with 2023 contract year	Chapter 5: Covered Services	01/01/2023
Addition	Claims Correspondence	Updated new mailing address for claims correspondence	Chapter 17: Encounters, Billing, and Claims	04/03/2023
Addition	Prenatal Services	Added coverage detail for prenatal services	Chapter 5: Covered Services	01/01/2022
New	Provider EFT/ERA Registration Services	Added information for the required use of Change Healthcare EERS system	Chapter 17: Encounters, Billing, and Claims	01/27/2023

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Welcome

Welcome to Aetna Better Health Inc., a Louisiana corporation, d/b/a Aetna Better Health® of Louisiana. Our ability to provide excellent service to our members is dependent on the quality of our provider network. By joining our network, you are helping us serve those Louisianans who need us most.

Aetna Medicaid and Schaller Anderson

Aetna expanded its Medicaid services in 2007, when it purchased Schaller Anderson, an Arizona-based, nationally recognized health care management company with more than two decades of Medicaid experience.

When Schaller Anderson was formed in 1986, Medicaid managed care was a new concept that had not been tried anywhere else in the country on the scale that the state had adopted. Schaller Anderson's founders were key visionaries in the development of the Arizona Health Care Cost Containment System (AHCCCS). The program soon became a model for states moving into Medicaid managed care.

About Aetna Better Health of Louisiana

Aetna Medicaid has been a leader in Medicaid managed care since 1986 and currently serves almost 3 million individuals in 16 states. An Aetna Medicaid affiliate has recently been awarded a contract in Louisiana to operate a Medicaid program. Aetna Medicaid affiliates currently own administer or support Medicaid programs in Arizona, California, Florida, Illinois, Kansas, Kentucky, Louisiana, Maryland, Michigan, New Jersey, New York, Ohio, Pennsylvania, Texas, Virginia, and West Virginia.

Aetna Medicaid has more than 30 years' experience in managing the care of the most medically vulnerable, using innovative approaches to achieve successful health care results.

Experience and Innovation

We have more than 30 years' experience in managing the care of the most medically vulnerable. We use innovative approaches to achieve both successful health care results and maximum cost outcomes.

We are dedicated to enhancing member and provider satisfaction, using tools such as predictive modeling, care management, and state-of-the art technology to achieve cost savings and help members attain the best possible health, through a variety of service models.

We work closely and cooperatively with physicians and hospitals to achieve durable improvements in service delivery. We are committed to building on the dramatic improvements in preventive care by facing the challenges of health literacy and personal barriers to healthy living.

Today Aetna Medicaid owns and administers Medicaid managed health care plans for more than two million members. In addition, Aetna Medicaid provides care management services to hundreds of thousands of high-cost, high-need Medicaid members. Aetna Medicaid utilizes a variety of delivery systems, including fully capitated health plans, complex care management, and administrative service organizations.

Meeting the Promise of Managed Care

Our state partners choose us because of our expertise in effectively managing integrated health models for Medicaid that provides quality service while saving costs. The members we serve know that everything we do begins with the people who use our services – we care about their status, their quality of life, the environmental conditions in which they live and their behavioral health risks. Aetna Medicaid has developed and implemented programs that integrate prevention, wellness, disease management and care coordination.

We have particular expertise in successfully serving children with special health care needs, children in foster care, persons with developmental and physical disabilities, women with high-risk pregnancies, and people with behavioral health issues.

Aetna Medicaid distinguishes itself by:

- More than 30 years' experience managing the care and costs of the Temporary Assistance for Needy Families (TANF), Children's Health Insurance Program (CHIP) and Aged, Blind and Disabled (ABD) (both physical and behavioral) populations
- More than 30 years' experience managing the care and costs of the developmentally disabled population, including over 9,000 members served today through the Mercy Care Plan in Arizona
- 20 years' experience managing the care and costs of children and youth in foster care or other alternative living arrangements
- Operation of a number of capitated managed care plans
- Participation on the Center for Health Care Strategies (CHCS) Advisory Committee, as well as specific programs and grants, since CHCS' inception in 1995
- Local approach – recruiting and hiring staff in the communities we serve

About the Louisiana Medicaid Managed Care Program

The Louisiana Bureau of Health Services Financing, an agency under the Louisiana Department of Health (LDH) administers the state-and federally-funded Healthy Louisiana Medicaid program for certain groups of low- to moderate-income adults and children.

About the Medicaid Managed Care Program

Aetna Better Health of Louisiana was chosen by LDH to be one of the Healthy Louisiana Plan to arrange for care and services by specialists, hospitals, and providers including member engagement, which includes outreach and education functions, grievances, and appeals.

Aetna Better Health of Louisiana is offered statewide.

Region Description: Associated Parishes (Counties)

Gulf	Capital	South Central	North
Ascension	East Baton Rouge	Acadia	Bienville
Assumption	East Feliciana	Allen	Bossier
Jefferson	Iberville	Avoyelles	Caddo
Lafourche	Livingston	Beauregard	Caldwell
Orleans	Pointe Coupee	Calcasieu	Claiborne
Plaquemines	St. Helena	Cameron	DeSoto
St. Bernard	St. Tammany	Catahoula	East Carroll
St. Charles	Tangipahoa	Concordia	Franklin
St. James	Washington	Evangeline	Jackson
St. John	West Baton Rouge	Grant	Lincoln
St. Mary	West Feliciana	Iberia	Madison
Terrebonne		Jefferson Davis	Morehouse
		Lafayette	Natchitoches
		LaSalle	Ouachita
		Rapides	Red River
		St. Landry	Richland
		St. Martin	Sabine
		Vermilion	Tensas
		Vernon	Union
		Winn	Webster
			West Carroll

Disclaimer
Providers are contractually obligated to adhere to and comply with all terms of the plan and your Aetna Better Health of Louisiana Provider Agreement, including all requirements described in this Manual, in addition to all federal and state regulations governing a provider. While this Manual contains basic information about Aetna Better Health of Louisiana, LDH requires that providers fully understand and apply LDH requirements when administering covered services. Please refer to **www.LDH.la.gov/** for further information on LDH.

Aetna Better Health of Louisiana Policies and Procedures
Our comprehensive and robust policies and procedures are in place throughout our entire Health Plan to verify all compliance and regulatory standards are met. Our policies and procedures are reviewed on an annual basis and required updates are made as needed.

Eligibility
To be eligible for Louisiana Medicaid, a person must meet a categorical eligibility requirement, including but not limited to:

- Children under nineteen (19) years of age including those who are eligible under Section 1931 poverty-level related groups and optional groups of older children in the following categories:
    - TANF - Individuals and families receiving cash assistance through FITAP (Families in Temporary Need of Assistance)
    - CHAMP-Child Program
    - Deemed Eligible Child Program
    - Youth Aging Out of Foster Care. Children under age 21 who were in foster care and already covered by Medicaid on their 18th birthday but have aged out of foster care.
    - Former Foster Care Children. Members aged 18 -26 who had Medicaid and were in foster care on their 18th birthday.
    - Regular Medically Needy Program
    - LaCHIP Program
    - Children who are eligible for Medicaid due to blindness or disability
    - Children receiving foster care or adoption assistance, in foster care, or in an out of home placement
    - Children with Special Health Care Needs
    - NOTE: Some children under nineteen (19) years of age with disabilities may be qualified to receive Medicaid coverage, regardless of parental income. See Act 421 Children's Medicaid Option (TEFRA) for more information.
- Parents and Caretaker Relatives eligible under Section 1931 of the Social Security Act including:
    - Parents and Caretaker Relatives Program
    - TANF (FITAP) Program
    - Regular Medically Needy Program
- Pregnant Women - Individuals whose basis of eligibility is pregnancy, who are eligible only for pregnancy related services [42 CFR§440.210(2)] including:
    - LaMOMS (CHAMP-Pregnant Women)
    - LaCHIP Phase IV Program
- Breast and Cervical Cancer (BCC) Program
- Aged, Blind and Disabled Adults (ABD) – Individuals who do not meet any of the conditions for mandatory enrollment in a managed care organization for specialized behavioral health only.
- Continued Medicaid Program
- Individuals receiving Tuberculosis (TB) related services through the TB Infected Individual Program

Act 421 Children's Medicaid Option (TEFRA)
Beginning 1/1/2022, Louisiana Medicaid will launch TEFRA, allowing certain children under 19 years of age with disabilities to receive Medicaid coverage regardless of parental income.

The TEFRA option disregards family income for children with disabilities who meet specific criteria, so they may qualify for Medicaid to cover the services they need to grow and thrive while living at home.

To qualify, children must have a disability that is recognized under the definition utilized in the Supplemental Security Income program of the Social Security Administration and must meet basic Medicaid and institutional level-of-care requirements. Additionally, their care must cost less at home than in an institution.

Applications for the TEFRA program may be submitted beginning January 1, 2022. Applicants must complete four steps which include 1) Medicaid Application, 2) Level of Care Assessment at your Local Governing Entity, 3) Disability Determination, and 4) Enrollment/Service Coverage through a Healthy Louisiana plan.

Consideration for Act 421 coverage will not occur before January 1, 2022. Anyone applying before that date will only be considered for existing Medicaid programs. Visit http://www.ldh.la.gov/act421 for additional information and answers to frequently asked questions

On 1/1/2022, potential applicants can enroll via the LDH self-service portal or by contacting Louisiana Medicaid at 888-342-6207.

Mandatory Populations for Behavioral Health Only

Some people who are eligible for behavioral health services only must pick a Healthy Louisiana plan. These members will only get specialized behavioral health services from us. The mandatory populations include:

- Individuals residing in Nursing Facilities (NF)
- Individuals under the age of 21 residing in Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD)

Mandatory Populations for Behavioral Health and Non-Emergent Medical Transportation services only

Members who receive both Medicaid and Medicare (Medicaid dual eligible) must pick a Healthy Louisiana plan. This does not include those members who reside in a nursing facility or ICF/DD. Medicaid dual eligible are only able to receive behavioral health and NEMT services from us.

Voluntary opt-in populations

Members who must enroll in a Healthy Louisiana plan for behavioral health and non-emergency medical transportation (NEMT) services can choose to also enroll for their other covered Medicaid services. Members can change their mind and return to legacy Medicaid for other covered Medicaid services at any time, but members will have to stay with your Healthy Louisiana Plan for behavioral health and NEMT services. If a member chooses to leave Healthy Louisiana for other Medicaid services, they have to wait until the next annual open enrollment to enroll again. This applies to members who are in one of these groups:

- Members who do not have Medicare and who receive services through any of the following 1915(c) Home and Community-Based Waivers:
    - Adult Day Health Care (ADHC) - Direct care in a licensed adult day health care facility for those individuals who would otherwise require nursing facility services;
    - New Opportunities Waiver (NOW) – Services to individuals who would otherwise require ICF/DD services
    - Children's Choice (CC) - Supplemental support services to disabled children under age 18 on the NOW waiver registry
    - Residential Options Waiver (ROW) – Services to individuals living in the community who would otherwise require ICF/DD services
    - Supports Waiver – Services to individuals 18 years and older with mental retardation or a developmental disability which manifested prior to age 22
    - Community Choices Waiver (CCW) – Services to persons aged 65 and older or, persons with adult-onset disabilities age 22 or older, who would otherwise require nursing facility services
- Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the Office for Citizens with Developmental Disabilities' (OCDD's) Request for Services Registry who are Chisholm Class Members.

Excluded populations

Individuals in an "excluded population" may not enroll in the Healthy Louisiana Program. "Excluded populations include:

- Adults aged 21 and older residing in Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD)

- Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE), a community-based alternative to placement in a nursing facility that includes a complete "managed care" type benefit combining medical, social, and long-term care services
- Individuals with a limited eligibility period including:
    - Spend-down Medically Needy Program – An individual or family who has income in excess of the prescribed income standard can reduce excess income by incurring medical and/or remedial care expenses to establish a temporary period of Medicaid coverage (up to 3 months)
    - Emergency Services Only - Emergency services for aliens who do not meet Medicaid citizenship/ 5-year residency requirements
    - Greater New Orleans Community Health Connection (GNOCHC) Program.

Choosing a PCP

- Members need to pick a PCP that is in the Plan provider network.
- Each eligible family member does not have to have the same PCP.
- If a member does not pick a PCP, we will pick one for the member.
- Providers must verify eligibility each and every visit by the member.

All providers, regardless of contract status, must verify a member's enrollment status prior to the delivery of non-emergent, covered services. A member's assigned provider must also be verified prior to rendering primary care services.

When a member first enrolls in our Plan, the Enrollment Broker will help them pick a health plan with whom their PCP participates. We will do our best to make sure they get to keep that PCP they chose. Sometimes we cannot assign the member to the PCP they pick. When this happens, we will pick a PCP for the member. The PCP's name and phone number will be on the member's ID card. The member can call us at any time to change PCPs. We might pick a PCP for the member if:

- They didn't pick a PCP when they enrolled
- The PCP they picked isn't taking new members
- The PCP they picked only sees certain members, such as pediatricians who only see children.

If we have to pick a PCP for the member, we will try to find the PCP that is close to member and best fits their needs. We look for:

- The member's recent PCP
- The member's family member's PCP
- The member's zip code
- The member's age

<u>PCP auto assignment methodology and algorithm used for members that do not make a PCP selection</u>
Aetna Better Health uses an auto assigned PCP logic which includes:

- First search for previous enrollment and PCP assignments history, to initiate re-assignment
- Geographic region (zip code) search applied first
- Age/Gender preferences/restrictions then applied based on incoming beneficiary information
- Providers with open panels matching geo/age/gender identified
- Assignment made

<u>Changing PCPs</u>
A member, at any time during enrollment, may select a new PCP. A member may change their PCP for any reason. After a member has been assigned to a PCP for at least 90 days, a member may also be prospectively re-assigned to a different PCP based on ABHLA's claims analysis or network availability of the most appropriate PCP. A member will be notified of the change of PCP, but a member authorization may not be required.

<u>Quarterly Member Assignment/Member Reassignment</u>

Aetna Better Health of Louisiana, on a quarterly basis, will conduct a claims analysis using no less than 12 months and no more than 18 months of claims data and will prospectively attribute members to primary care providers where care is being delivered.

The results of the above claims analyses will be used to determine enrollee reassignment. An enrollee will be eligible for reassignment only if they have visited an unassigned PCP at least once within the previous 12 months. Additionally,

- If the enrollee has seen an unassigned PCP within the same Tax ID Number (TIN) as the assigned PCP, the enrollee will not be reassigned.
- If an enrollee has not seen the assigned PCP and has seen multiple unassigned PCPs, the enrollee will be assigned to the PCP with the most visits.
    - If the enrollee has the same number of visits with multiple unassigned PCPs, the enrollee will be assigned to the most recently visited PCP.
- An enrollee will also be eligible for reassignment to another PCP if they have not visited any PCP within the previous 12 months.
- If the enrollee has an established relationship, defined by at least one claim within the previous 12 months, with an unassigned PCP, the enrollee will be reassigned appropriately, even if the unassigned PCP's panel shows that it is closed. The enrollee-PCP relationship takes priority over a closed panel.

All reassignments shall be prospective.

Provider Notification of Reassignment

ABHLA will publish the results of the claims analysis to the provider portal on the 15th calendar day of the second month of each quarter. When this due date falls on a weekend or a State-recognized holiday, the ABHLA will publish the results on the next business day.

The claims analysis results will be available for downloading and exporting into Microsoft® Excel®. The results will identify all enrollees eligible for reassignment from the PCP along with enrollees eligible for reassignment to the PCP. Enrollees identified as eligible for reassignment to the PCP shall be shared as informational only, considering this data is subject to change via the Provider Dispute Protocol.

New enrollees will be flagged in the claims analysis results so that providers may easily identify enrollees on their rosters/panels. Additionally, auto-assigned enrollees will be designated with their own, easily identifiable flag. This flag is for all enrollees, not solely for reassigned enrollees.

Provider Dispute Protocol

Providers have 15 business days to review changes made to their rosters prior to any changes being made. If a Provider chooses to dispute any member assignments, they should contact their Provider Relations Liaison by emailing the LA Provider Relations department at LAProvider@aetna.com or by calling 1-855-242-0802. to initiate their dispute. To successfully dispute any re-assignment, the provider must show documentation (medical record, proof of billed claim, etc. for at least one DOS) that they have seen the enrollee(s) during the previous 12-month period.

A primary care provider may request that a member be re-assigned to another provider based on the following criteria:

- ABHLA conducts a claims data analysis within 30 days of the request and determines that the member is receiving care from another Provider that supports an existing PCP relationship. A response will be sent to the provider with the rationale used to make the decision.
- The member represents a substantiated safety threat to provider, office staff or other patients.
- The Provider must make the request by including:
    - The member's full name
    - MCO ID #
    - The reason for the request
    - The requesting PCP's NPI #

ABHLA will notify enrollees of reassignment.

Within 15 calendar days after the quarter, ABHLA will report the following data to LDH:

- number of PCPs included in the analysis
- number of PCPs with at least 1 enrollee reassigned from their panel
- number of PCPs with at least 1 enrollee reassigned to their panel
- name(s) of PCPs with no changes to their panel(s) from the reassignment analysis

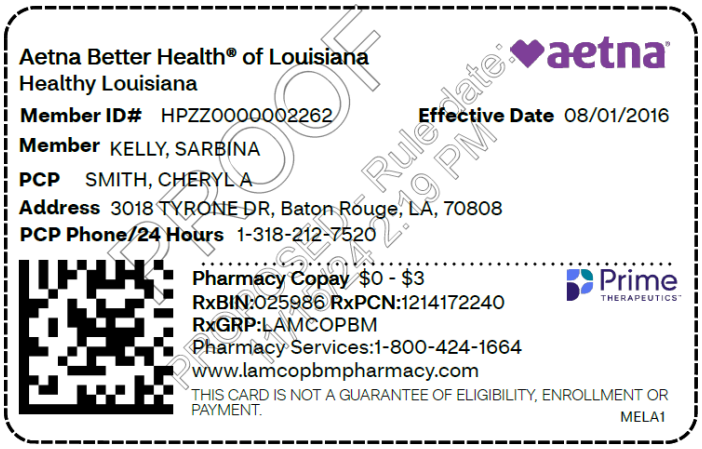
Member ID

Members should present their ID card at the time of service.
The member ID card contains the following information:

- Member Name
- Member ID Number
- Date of Birth of Member
- Member's Gender
- PCP Name
- PCP Phone Number
- Effective Date of Eligibility
- Claims address
- Emergency Contact Information for Member
- Health Plan Name
- Aetna Better Health of Louisiana's Website
- Carrier Group Number
- RX Bin Number
- RX PCN Number
- RX Group Number
- Prime Therapeutics (For Pharmacists use only)

Sample ID Card

Front:



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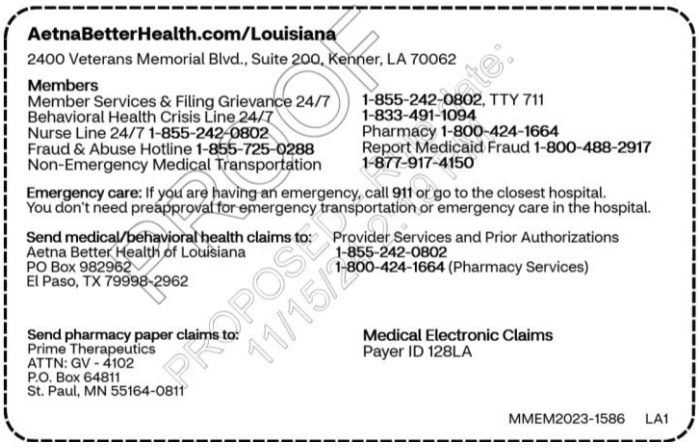

Model of Care

Integrated Care Management

Aetna Better Health of Louisiana's Integrated Care Management (ICM) Program uses a Bio-Psycho-Social (BPS) model to identify and reach our most vulnerable members. The approach matches members with the resources they need to improve their health status and to sustain those improvements over time. We use evidence-based practices to identify members at highest risk of not doing well over the next twelve (12) months and offer them intensive care management services built upon a collaborative relationship with a single clinical Case Manager, their caregivers, and their Primary Care Provider (PCP). This relationship continues throughout the care management engagement. We offer members who are at lower risk supportive care management services. These include standard clinical care management and service coordination and support. Disease management is part of all care management services that we offer. Aetna Better Health also accepts referrals (by mail, fax, phone, email) for care management from practitioners, providers, members, caregivers, health information lines, facility discharge planners, and plan staff such as those from Member Services, Care Management and Utilization Management.

The ICM Interventions and Services are detailed below:

ICM Interventions and Services	
ICM Service Level	**Care Management Interventions**
Intensive: Complex Case Management and Chronic Condition Management (Disease Management)	• Outreach/Enrollment • Welcome letter • Face to face visits • PCP notification of enrollment, education about the program and services and how they can best support their patient[1] • Encouraging members to communicate with their care and service providers • Comprehensive bio-psychosocial assessment including behavioral health and substance use screening • Condition specific assessments for physical and behavioral health • Case Formulation/Synthesis (summary of the member's story) • Integrated plan of care and service plans (if member is LTSS eligible) • Chronic condition management • Care Planning • Member education and coaching to self-manage their conditions and issues • Monthly (minimum) care plan updates based on progress toward goals • Member contacts as clinically indicated and face to face if indicated • Complex care coordination with both internal and the member's multi-disciplinary care team which includes the member's identified support system • Case rounds • Integrated care team meetings (duals & LTSS) • Annual newsletter for primary chronic condition • Krames educational sheets
Supportive:	• Outreach/Enrollment • Welcome letter

ICM Interventions and Services	
ICM Service Level	**Care Management Interventions**
Supportive Standard Care Management and Chronic Condition Management (Disease Management)	• Face to face visits optional • PCP notification of enrollment, education about the program and services and how they can best support their patient • Condition specific assessments for conditions of focus • Bio-psychosocial care plan which includes activities for chronic conditions and service plans • Chronic condition management • Coaching on the management of conditions and issues of self-care • Encouraging members to communicate with their care and service providers • Education on disease process, self-management skills, and adherence to recommended testing and treatment • Quarterly (minimum) care plan updates • Member contacts as clinically indicated • Care team coordination • Case rounds • Integrated care team meetings (duals & LTSS) • Bi-annual newsletter for primary chronic condition • Krames educational sheets
Population Health Monitoring, follow up and education for low risk members	• Low/No Risk pregnant members: Quarterly screening to identify risk factors • Dually enrolled Medicare-Medicaid: Annual HRQ, low risk care plans, Krames materials • Welcome letter and bi-annual newsletter for low risk chronic condition management • Special populations: monitoring/tracking per state requirements • PCP notification of enrollment, education about the program and services and how they can best support their patient • Not applicable for LTSS

About this Provider Manual

This Provider Manual service as a resource and outlines operations for Aetna Better Health of Louisiana's Healthy Louisiana program. Through the Provider Manual, providers should be able to identify information on the majority of issues that may affect working with Aetna Better Health of Louisiana. Medical, dental, and other procedures are clearly denoted within the Manual.

Aetna Better Health of Louisiana is updated and made available to providers via the Aetna Better Health website at **AetnaBetterHealth.com/Louisiana**. Aetna Better Health of Louisiana annually notifies all new and existing participating providers in writing that the Provider Manual is available on the website. The Aetna Better Health of Louisiana Provider Manual is available in hard copy form or on CD-ROM at no charge by contacting our Provider Experience Department at **1-855-242-0802**. Otherwise, for your convenience Aetna Better Health of Louisiana will make the Provider Manual available on our website at **AetnaBetterHealth.com/Louisiana**.

This manual is intended to be used as an extension of the Participating Health Provider Agreement, a communication tool and reference guide for providers and their office staff.

For the purpose of this manual, "provider" refers to practitioners (licensed health care professionals who provide health care services) and providers (institutions or organizations that provide services) that have agreed to provide Covered Services to health plan members pursuant to a Participating Health Provider Agreement ("contract").

About Patient-Centered Medical Homes (PCMH)

A Patient-Centered Medical Home (PCMH), also referred to as a "health care home," is an approach to providing comprehensive, high-quality, individualized primary care services where the focus is to achieve optimal health outcomes. The PCMH features a personal care clinician who partners with each member, their family, and other caregivers to coordinate aspects of the member's health care needs across care settings using evidence-based care strategies that are consistent with the member's values and stage in life. If you are interested in becoming a PCMH, please contact us at **1-855-242-0802**.

Providers who have additional questions can refer to the following phone numbers:

Important Contacts	Phone or Online	FAX	Hours and Days of Operation (excluding State holidays)
Aetna Better Health of Louisiana	**1-855-242-0802** (follow the prompts in order to reach the appropriate departments) Provider Experience Department Member Services Department (Eligibility Verifications, education, grievances) **AetnaBetterHealth.com/Louisiana**	Individual departments are listed below	7 AM-7 PM CT Monday-Friday 7 AM-7 PM CT Monday-Friday 24 hours / 7 days per week Members have access to Services for Hearing Impaired (TTY) Louisiana Relay Services for Hearing-Impaired Members – Toll-Free **1-800-846-5277**
Aetna Better Health of Louisiana Behavioral Health Crisis Line	**1-855-242-2735**	N/A	24 hours / 7 days per week
Aetna Better Health of Louisiana – Care Management	**1-855-242-0802**	Individual departments are listed below	
Aetna Better Health of Louisiana Prior Authorization Department	See Program Numbers Above and Follow the Prompts	Individual departments are listed below	24 hours / 7 days per week
Aetna Better Health of Louisiana Compliance Hotline (Reporting Fraud, Waste or Abuse) Providers may remain anonymous.	**1-855-725-0288**	N/A	24 hours / 7 days per week through Voice Mail inbox
Aetna Better Health of Louisiana Special Investigations Unit (SIU) (Reporting Fraud, Waste or Abuse) Providers may remain anonymous.	**1-800-338-6361**	N/A	24 hours / 7 days per week Providers have access to Member Services staff and UM staff during normal business hours as well as after hours. Should our staff need to initiate or return a call regarding UM issues, staff will identify themselves by name, title, and organization name

Aetna Better Health of Louisiana Departments	Fax Numbers
Member Services	**1-855-853-4936**
Provider Experience	**1-844-521-9775**
Provider Claim Disputes	**1-860-607-7657**
Care Management	**1-866-776-2813**
Medical Prior Authorization	**1-844-227-9205**
Behavioral Health Prior Authorization	**1-844-634-1109**

Community Resource	Contact Information
Louisiana Tobacco Quitline	**1-800-QUIT-NOW** (**1-800-784-8669**) TTY **1-866-228-4327** Website**: http://quitwithusla.org/**

Contractors	Phone or Online	Facsimile	Hours and Days of Operation (excluding State holidays)
Interpreter Services Language interpretation services, including sign language, special services for the hearing impaired.	Please contact Member Services at **1-855-242-0802** (for more information on how to schedule these services in advance of an appointment)	N/A	24 hours / 7 days per week
Prime Therapeutics (PBM)	Help Desk**: 1-800-424-1664** Prior Auth**: 1-800-424-1664** **www.covermymeds.com**	1-800-424-7402	24 hours / 7 days per week
EyeMed - Vision Vendor	**1-888-747-0449**	N/A	Mon-Fri: 8 AM – 11 PM CST Sun: 11 AM – 8 PM CST
DentaQuest	**1-844-234-9834**	N/A	7 AM-7 PM CT Monday-Friday
Lab – Quest Diagnostics (Preferred Lab) **www.questdiagnostics.com/home.html**	Please visit the website for additional information.	Please visit the website for additional information	Please visit the website for additional information.
Durable Medical Equipment- DME	Please see our online provider search tool for details surrounding DME providers. **AetnaBetterHealth.com/Louisiana**	N/A	N/A
Transportation (non-emergency medical transportation & non-emergency ambulance transportation)	For members: Reservations (call 48 hours in advance): **1-877-917-4150** 24-Hour Ride Assistance: **1-877-917-4151** TTY: **1-866-288-3133**	N/A	7AM-7PM CT Monday-Friday
Magellan Specialized Behavior Health	**1-800-424-4489**	N/A	
Acadian Health Acute Care at Home	To schedule a visit for a member: **1-337-704-5829** or **1-844-987-1395**	N/A	Mon-Sun: 8 AM – 10 PM CST

Behavioral Health Services please see our online provider search tool for details surrounding Behavioral Health Services.

Agency Contacts & Important Contacts	Phone or Online	Facsimile	Hours and Days of Operation (excluding State holidays)
Louisiana Department of Health Bureau of Health Services Financing TTY **1-800-220-5404**	**1-888-342-6207**	**1-877-523-2987**	Monday through Friday from 8 AM to 4:30 PM
Change Healthcare Customer Service	**1-800-845-6592** Online: https://client-support.changehealthcare.com	N/A	24 hours / 7 days per week
Louisiana Relay	**1-800-846-5277**	N/A	24 hours / 7 days per week

Reporting Suspected Neglect or Fraud			
The Louisiana Department of Children and Family Services Child Abuse Hotline	**1-855-452-5437**	N/A	24 hours / 7 days per week
The National Domestic Violence Hotline	**1-800-799-SAFE** (7233)	N/A	24 hours / 7 days per week
The Louisiana Medicaid Fraud Division of the Louisiana Department of Health	**1-800-488-2917** (for provider fraud) **1-888-342-6207** (for recipient fraud)		
The Federal Office of Inspector General in the U.S. Department of Health and Human Services (Fraud)	**1-800-HHS-TIPS (1-800-447-8477)**		

In addition to the telephone numbers above, participating providers may access the Aetna Better Health of Louisiana website 24 hours a day, 7 days a week at **AetnaBetterHealth.com/Louisiana** for up-to-date information, forms, and other resources such as:

- Provider quick reference guide
- Member Rights and Responsibilities
- Searchable Provider Directory
- Credentialing Information
- Prior Authorization Grid
- Clinical Practice Guidelines
- Adult and Child Preventive Health Guidelines
- Member Handbook and Benefits
- Appeals Information and Forms
- Provider Newsletters

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Provider Experience Department Overview

Our Provider Experience Department serves as a liaison between the Health Plan and the provider community. Our staff is comprised of Provider Experience Managers who conduct onsite provider training, problem identification and resolution, provider office visits, and accessibility audits.

Our Provider Experience Representatives are available by phone or email to provide telephonic or electronic support to all providers. Below are some of the areas where we provide assistance:

- Advise of an address change
- View recent updates
- Locate forms
- Review member information
- Check member eligibility
- Find a participating provider or specialist
- Submitting prior authorizations
- Review or search the Preferred Drug List
- Notify the plan of a provider termination
- Notify the plan of changes to your practice
- Advise of a Tax ID or National Provider Identification (NPI) Number change
- Obtain a secure web portal or member care Login ID
- Review claims or remittance advice

Our Provider Experience Department is responsible for the creation and development of provider communication materials, including the Provider Manual, Periodic Provider Newsletters, Bulletins, Fax/Email blasts, website notices and the Provider Orientation Kit.

Provider Orientation

Aetna Better Health of Louisiana provides initial orientation for newly contracted providers within 30 days of being placed on an active status with Aetna Better Health of Louisiana and before you see members. In follow up to initial orientation, Aetna Better Health of Louisiana provides a variety of provider educational forums for ongoing provider training and education, such as routine provider office visits, group or individualized training sessions on select topics (i.e. appointment time requirements, claims coding, appointment availability standards, member benefits, Aetna Better Health of Louisiana website navigation), distribution of Periodic Provider Newsletters and bulletins containing updates and reminders, and online resources through our website at **AetnaBetterHealth.com/Louisiana**.

Provider Inquiries

Providers may reach out to their individual Provider Experience representative for any and all questions including checking on the status of an inquiry, complaint, grievance, and appeal. A roster of Provider Experience Managers can be found on the provider website at **AetnaBetterHealth.com/Louisiana/Providers**. Providers can also contact us at **1-855-242-0802** between the hours of 7 AM and 7 PM, Monday through Friday, or email us at **LAProvider@aetna.com** Our Provider Experience Staff will respond as soon as possible.

Provider Enrollment

Beginning 6/1/2021, Louisiana Medicaid requires all* Medicaid Providers to enroll via the Louisiana Medicaid Portal at lamedicaid.com. This includes current managed care organization (MCO) only providers, Dental Benefits Program Manager (DBPM) providers, Coordinated System of Care (CSoC) providers, fee-for-service providers, and any new providers enrolling for the first time. Enrollment must be completed for every provider type. Enrollment guidance can be found at **www.ldh.la.gov/medicaidproviderenrollment**.

Per 42 CFR § 455.414, all Medicaid-enrolled providers, including ordering or referring providers, must revalidate their enrollment information, regardless of provider type, at least every five years. However, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) providers must revalidate their information every three years to maintain their participation in Louisiana Medicaid. See **LDH Informational Bulletin 25-14** for more information.

Providers participating in the ABHLA network prior to March 31, 2021, must have enrolled no later than September 30, 2022. New ABHLA providers will be invited to enroll in the portal at a later date.

Providers who were required to enroll but did not complete enrollment by June 30, 2023, were deactivated, and their patients have been assigned to another PCP. Providers who did not complete the enrollment process by June 30, 2023, may not be reimbursed for claims with dates of service between January 1, 2023, and June 30, 2023.

Effective January 1, 2024, claims will deny for providers that have not completed enrollment for each provider type associated with their NPI. Providers must have all provider types enrolled by December 31, 2023, to avoid claim denials. Providers should verify enrollment status through the provider **enrollment tool**.

For newly contracted credentialed providers, Medicaid Provider Enrollment will occur every two months beginning October 25, 2024. Providers will receive an invitation letter containing provider information and detailed enrollment instructions to enroll through the web portal. You must complete your enrollment for each provider type within 120 days or claims will deny. Please keep in mind that the enrollment process takes several weeks to complete.

* Providers currently participating in the ABHLA network must also validate their information and sign the state's provider participation agreement through the Louisiana Medicaid Portal within six months of the 7/1/2021 launch date. Any existing Medicaid provider who does not complete the enrollment and screening process through the new portal within the time frame indicated on the invitation that will be mailed to them will have their claims denied after that time period. Providers enrolled with ABHLA will receive an invitation sent to the mailing address that is on file with ABHLA. (Access to and enrollment in the new portal is being staggered to avoid overwhelming the system.)

To update your email address with us, **contact your regional representative**.

Apply for Participation in the ABHLA Network

Only providers who are successfully enrolled and screened with Louisiana Medicaid may apply for participation in the Aetna Better Health of Louisiana network.

Our Provider Contracting team supports network development and contracting with multiple functions, including the evaluation of the provider network and compliance with regulatory network capacity standards.

If you are interested in applying for participation in our Aetna Better Health of Louisiana network, please visit our website at **AetnaBetterHealth.com/Louisiana**, and complete the provider application forms (directions will be available online). If you would like to speak to a representative about the application process or the status of your application, please contact the Provider Experience Manager for your area or call us at **1-855-242-0802**. A Provider Experience Manager can also advise if Aetna Better Health of Louisiana is accepting new providers in a specific region.

A list of Provider Experience Managers can be found on our website at **AetnaBetterHealth.com/Louisiana/Providers**.

If you would like to mail your application, please mail to:

Aetna Better Health of Louisiana
Attention: Provider Experience
2400 Veterans Memorial Blvd., Suite 200
Kenner, LA 70062

Provider Responsibilities Overview

This section outlines general provider responsibilities; however, additional responsibilities are included throughout this Manual. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with all terms of the Louisiana Healthy Louisiana Program, the Request for Proposal between LDH and Aetna Better Health and Louisiana, and your Provider Agreement, and requirements outlined in this Manual. Aetna Better Health of Louisiana may or may not specifically communicate such terms in forms other than your Provider Agreement and this Manual.

Providers must cooperate fully with state and federal oversight and prosecutorial agencies, including but not limited to, the Louisiana Department of Health (LDH), The Louisiana Medicaid Fraud Division of the Louisiana Department of Health, Medicaid Fraud Control Unit (MFCU), Health and Human Services – Office of Inspector (HHS-OIG), Federal Bureau of Investigation (FBI), Drug Enforcement Administration (DEA), Food and Drug Administration (FDA), and the U.S. Attorney's Office.

Providers must act lawfully in the scope of practice of treatment, management, and discussion of the medically necessary care and advising or advocating appropriate medical care with or on behalf of a member, including providing information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered including all relevant risk, benefits and consequences of non-treatment. Providers must also assure the use of the most current diagnosis and treatment protocols and standards. Advice given to potential or enrolled members should always be given in the best interest of the member. Providers may not refuse treatment to qualified individuals with disabilities, including but not limited to individuals with Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS).

Unique Identifier/National Provider Identifier

Providers who provide services to Aetna Better Health of Louisiana members must obtain identifiers. Each provider is required to have a unique identifier, and qualified providers must have a National Provider Identifier (NPI) on or after the compliance date established by the Centers for Medicare and Medicaid Services (CMS).

Appointment Availability Standards

Providers are required to schedule appointments for eligible members in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the member's past and current medical history. Providers are to ensure that the hours of operation being offered to all Medicaid members are no less than and/or equal to those offered to commercial members. Our Provider Experience Department will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards. Providers are contractually required to meet the Louisiana Department of Health (LDH) and the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, taking into account the urgency of and the need for the services.
The table below shows appointment wait time standards for Primary Care Providers (PCPs), Obstetrics and Gynecologist (OB/GYNs), and high volume Participating Specialist Providers (PSPs).

Emergency	**Urgent**	**Non-urgent**	**Preventive/ Routine Care**	**Specialty**	**Behavioral Health**	**Lab & X-ray**
Emergent or emergency	Urgent Care within twenty-	Non-urgent sick care	Routine physical	Specialty care consultation	Care for urgent non-	Lab and X-ray services

visits immediately upon presentation at the service delivery site. Emergency services must be available at all times and an appointment shall be arranged within one (1) hour of request.	four (24) hours; Provisions must be available for obtaining urgent care 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by Aetna Better Health of Louisiana through other arrangements.	within 72 hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition.	health, non-urgent, or preventive care visits within 6 weeks. Routine, behavioral healthcare, non-urgent appointments shall be arranged within fourteen (14) days of referral.	within 1 month of referral or as clinically indicated	life threatening emergency within 48 hours of request for care Initial visit for routine care within 14 business days Follow-up routine care within 30 days of initial visit Psychiatric inpatient hospital (involuntary) within 24 hours Psychiatric inpatient hospital (emergency involuntary) within 4 hours Psychiatric inpatient hospital (voluntary) within 24 hours PRTF within 20 calendar days ASAM Level 3.3, 3.5, 3.7 within 10 business days Residential withdrawal management within 24 hours when	(usual and customary) not to exceed three weeks for regular appointments and 48 hours for urgent care or as clinically indicated

					medically necessary	

Prenatal Care: Members will be seen within the following timeframes: (Initial appointment for prenatal visits for newly enrolled pregnant women will meet the following timetables from the postmark date the Healthy Louisiana Plan mails the member's welcome packet for members whose basis of eligibility at the time of enrollment in the Healthy Louisiana Plan is pregnancy. The timeframes below apply for existing member or new members whose basis of eligibility is something other than pregnancy from the date the Healthy Louisiana Plan or their subcontracted provider becomes aware of the pregnancy.)
• Within their first trimester within 14 days
• Within the second trimester within 7 days
• Within their third trimester within 3 days
• High risk pregnancies within 3 days of identification of high risk by the Healthy Louisiana Plan or maternity care provider, or immediately if an emergency exists
Notification of Pregnancy Completing the Notification of Pregnancy form as early as possible allows us to best service our members to achieve a healthy pregnancy outcome. Please fill out this electronic form and submit so that it may directly reach our care management team in an expedited manner. The completion of this form will help to identify high-risk pregnancies and assist in linking these members to case management enrollment. If you have any questions, please contact our Provider Experience department at **1-855-242-0802**. If you prefer to fax this form, you may fax to **1-866-776-2813.** Attn: Case Management

In office, waiting time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room. If a provider is delayed, patients must be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient must be offered a new appointment. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.

Please note that follow-up to ED visits must be in accordance with ED attending provider discharge instructions.

Telephone Accessibility Standards

Providers have the responsibility to make arrangements for after-hours coverage in accordance with applicable state and federal regulations, either by being available, or having on-call arrangements in place with other qualified participating Aetna Better Health of Louisiana providers for the purpose of rendering medical advice, determining the need for emergency and other after-hours services including, authorizing care and verifying member enrollment with us.

It is our policy that network providers cannot substitute an answering service as a replacement for establishing appropriate on call coverage. On call coverage response for routine, urgent, and emergent health care issues are held to the same accessibility standards regardless of whether after hours coverage is managed by the PCP, current service provider, or the on-call provider.

All Providers must have a published after hours telephone number and maintain a system that will provide access to primary care 24-hours-a-day, 7-days-a-week. In addition, we will encourage our providers to offer open access scheduling, expanded hours and alternative options for communication (e.g., scheduling appointments via the web, communication via e-mail) between members, their PCPs, and practice staff. Providers must return calls within 30 minutes. We will routinely measure the PCP's compliance with these standards as follows:

- Our medical and provider management teams will continually evaluate emergency room data to determine if there is a pattern where a PCP fails to comply with after-hours access or if a member may need care management intervention.

- Our compliance and provider management teams will evaluate member, caregiver, and provider grievances regarding after hour access to care to determine if a PCP is failing to comply on a monthly basis.

Providers must comply with telephone protocols for all of the following situations:

- Answering the member telephone inquiries on a timely basis
- Prioritizing appointments
- Scheduling a series of appointments and follow-up appointments as needed by a member
- Identifying and rescheduling broken and no-show appointments
- Identifying special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs)
- Triage for medical and dental conditions and special behavioral needs for noncompliant individuals who are mentally deficient

A telephone response should be considered acceptable/unacceptable based on the following criteria:
Acceptable – An active provider response, such as:

- Telephone is answered by provider, office staff, answering service, or voice mail.
- The answering service either:
  - Connects the caller directly to the provider
  - Contacts the provider on behalf of the caller and the provider returns the call
  - Provides a telephone number where the provider/covering provider can be reached
- The provider's answering machine message provides a telephone number to contact the provider/covering provider.

Unacceptable:

- The answering service:
  - Leaves a message for the provider on the PCP/covering provider's answering machine
  - Responds in an unprofessional manner
- The provider's answering machine message:
  - Instructs the caller to go to the emergency room, regardless of the exigencies of the situation, for care without enabling the caller to speak with the provider for non-emergent situations
  - Instructs the caller to leave a message for the provider
- No answer;
- Listed number no longer in service;
- Provider no longer participating in the contractor's network;
- On hold for longer than five (5) minutes;
- Answering Service refuses to provide information for after-hours survey;
- Telephone lines persistently busy despite multiple attempts to contact the provider.

Provider must make certain that their hours of operation are convenient to, and do not discriminate against, members. This includes offering hours of operation that are no less than those for non-members, commercially insured or public fee-for-service individuals.

In the event that a PCP fails to meet telephone accessibility standards, a Provider Experience Representative will contact the provider to inform them of the deficiency, educate the provider regarding the standards, and work to correct the barrier to care.

Covering Providers

Our Provider Experience Department must be notified if a covering provider is not contracted or affiliated with Aetna Better Health of Louisiana. This notification must occur in advance of providing authorized services. Depending on the Program, reimbursement to a covering provider is based on the fee schedule. If members have other insurance coverage, providers must submit a paper bill and primary carrier EOB for reimbursement or electronically the bill and primary carrier EOB. Medicaid is always payor of last result. Failure to notify our Provider Experience Department of covering provider affiliations or other insurance coverage may result in claim denials and the provider may be responsible for reimbursing the covering provider.

Verifying Member Eligibility

All providers, regardless of contract status, must verify a member's enrollment status prior to the delivery of non-emergent, covered services. A member's assigned provider must also be verified prior to rendering primary care services. Providers are NOT reimbursed for services rendered to members who lost eligibility or who were not assigned to the primary care provider's panel (unless s/he is a physician covering for the provider).

Member eligibility can be verified through one of the following ways:

- **Telephone Verification:** Call our Member Services Department to verify eligibility at **1-855-242-0802**. To protect member confidentiality, providers are asked for at least three pieces of identifying information such as the members identification number, date of birth and address before any eligibility information can be released.
- **Monthly Roster:** Monthly rosters are found on the Secure Website Portal (see **Provider Secure Web Portal** below).
- Contact our Provider Experience Department for additional information about securing a confidential password to access the site. Note: rosters are only updated once a month.

Provider Secure Web Portal

A new Secure Web Portal is located at **https://apps.availity.com/availity/web/public.elegant.login**, is a web-based platform that allows us to communicate member healthcare information directly with providers. This portal is also used by Aetna Commercial and Medicare, allowing providers to use one login for commercial, Medicare, and Aetna Medicaid. ABHLA providers have access to the following functions within this web-based portal:

- Single sign-on – One login and password allows you to move smoothly through various systems.
- Mobile interface – Enjoy the additional convenience of access through your mobile device.
- Personalized content and services – after log-in, you will find a landing page customized for you.
- Real-time data access – View updates as soon as they are posted.
- Better tracking – Know immediately the status of each claim submission and medical PA request.
- eReferrals – Go paperless. Refer patients to registered specialists electronically and communicate securely with the provider.
- Payer Spaces
- Claims Submission Link (Change Healthcare)
- Member Eligibility Search – Verify current eligibility of one or more members
- Panel Roster – View the list of members currently assigned to the provider as the PCP.
- Provider List – Search for a specific provider by name, specialty, or location.
- Claims Status Inquiry
- Appeals and Grievances
  - Grievance submission
  - Appeal submission
  - Grievance and appeals status
- Panel Roster-Panel lookup
- Reports
- Enhanced information – Analyze, track, and improve services and processes.
- Access to Member Care – You can connect to your patients and their care teams. You can access:
  - A real-time listing of your patients
  - Information on your practice
  - Email capability with care managers
- PDM/ProReports (Provider Deliverables Manager)
- Ambient (business intelligence reporting)
- Auto-authorizations – Depending on the auth type and service location, it is possible to receive an auto-approval on your request.
- Prior Authorization-Submission and status lookup

The legacy version of the Secure Web Portal is available here.

Member Care Web Portal

The Member Care Web Portal is another web-based platform offered by Aetna Better Health of Louisiana that allows providers access to the member's care plan, other relevant member clinical data, and securely interact with Care Management staff.

Providers are able to do the following via the Member Care Web Portal:
For their Practice:

- Providers can view their own demographics, addresses, and phone and fax numbers for accuracy.
- Providers can update their own fax number and email addresses.

For their Patients:

- View and print member's care plan* and provide feedback to Case Manager via secure messaging.
- View a member's profile which contains:
  - Member's contact information
  - Member's demographic information
  - Member's Clinical Summary
  - Member's Gaps in Care (individual member)
  - Member's Care Plan
  - Member's Service Plans
  - Member's Assessments responses*
  - Member's Care Team: List of member's Health Care Team and contact information (e.g., specialists, caregivers)*, including names/relationship
  - Detailed member clinical profile: Detailed member information (claims-based data) for conditions, medications, and utilization data with the ability to drill-down to the claim level*
  - High-risk indicator* (based on existing information, past utilization, and member rank)
  - Conditions and Medications reported through claims
  - Member reported conditions and medications* (including Over the Counter (OTC), herbals, and supplements)
- View and provide updates and feedback on "HEDIS Gaps in Care" and "Care Consideration" alerts for their member panel*
- Secure messaging between provider and Case Manager
- Provider can look up members not on their panel (provider required to certify treatment purpose as justification for accessing records)

*Any member can limit provider access to clinical data except for: Members flagged for 42 C.F.R. Part 2 (substance use) must sign a disclosure form and list specific providers who can access their clinical data.

For additional information regarding the Member Care Web Portal, please access the Member Care Web Portal Navigation Guide located on our website.

Preventive or Screening Services

Providers are responsible for providing appropriate preventive care to members. These preventive services include, but are not limited to:

- Age-appropriate immunizations, disease risk assessment and age-appropriate physical examinations.
- Well woman visits (one well-woman gynecological examination per calendar year for women aged 21 and over is covered, when performed by a primary care provider or gynecologist. No referral is required for gynecologist visits.)
- Age and risk appropriate health screenings.

Educating members on their own health care

Aetna Better Health of Louisiana does not prohibit providers from acting within the lawful scope of their practice and encourages them to advocate on behalf of a member and to advise them on:

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; and

- The member's right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

All providers may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

Emergency Services
Authorizations are not required for emergency services. In an emergency, please advise the member to go to the nearest emergency department. If a provider is not able to provide services to a member who needs urgent or emergent care, or if they call after hours, the member should be referred to the closest in-network urgent care or emergency department.

Urgent Care Services
As the provider, you must serve the medical needs of our members; you are required to adhere to all appointment availability standards. In some cases, it may be necessary for you to refer members to one of our network urgent care centers (after hours in most cases). Please reference the "Find a Provider" link on our website and select an "Urgent Care Facility" in the specialty drop down list to view a list of participating urgent care centers located in our network.

Periodically, Aetna Better Health of Louisiana will review unusual urgent care and emergency room utilization. Trends will be shared and may result in increased monitoring of appointment availability.

Primary Care Providers (PCPs)
The primary role and responsibilities of PCPs include, but are not limited to:

- Provide or arrange for urgent covered services as defined in your contract, including emergency medical services, to members on 24 hours per day, seven days per week basis.
- Providing primary and preventive care and acting as the member's advocate;
- Initiating, supervising, and coordinating referrals for specialty care and inpatient services, maintaining continuity of member care, and including, as appropriate, transitioning young adult members from pediatric to adult providers;
- Maintaining the member's medical record
- Provide to Members:
    - Office visits during regular office hours, ensuring that the hours of operation being offered to all Medicaid members are no less than and/or equal to those offered to commercial members.
    - Office visits or other services during non-office hours as determined to be medically necessary.
    - Respond to phone calls within a reasonable time and on an on-call basis 24 hours per day, seven days per week.

Primary Care Providers (PCPs) are responsible for rendering, or ensuring the provision of, covered preventive and primary care services for our members. These services will include, at a minimum, the treatment of routine illnesses, immunizations, health screening services, and maternity services, if applicable.

Primary Care Providers (PCPs) in their care coordination role serve as the referral agent for specialty and referral treatments and services provided to members assigned to them and attempt to verify coordinated quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

- Referring members to behavioral health providers, providers, or hospitals within our network, as appropriate, and if necessary, referring members to out-of-network specialty providers;
- Coordinating with our Prior Authorization Department with regard to prior authorization procedures for members;
- Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned members by other providers, specialty providers and hospitals; and
- Coordinating the medical care for the programs the member us assigned to, including at a minimum:
    - Oversight of drug regimens to prevent negative interactive effects
    - Follow-up for all emergency services
    - Coordination of inpatient care
    - Coordination of services provided on a referral basis, and

— Assurance that care rendered by specialty providers is appropriate and consistent with each member's health care needs

Primary Care Providers (PCPs) are responsible for establishing and maintaining hospital admitting privileges that are sufficient to meet the needs of members or entering into formal arrangements for management of inpatient hospital admissions of members. This includes arranging for coverage during leave of absence periods with an in-network provider with admitting privileges.

Specialty Providers
Specialty providers are responsible for providing services in accordance with the accepted community standards of care and practices. Specialists should provide services to members upon receipt of a written referral form from the member's PCP or from another Aetna Better Health of Louisiana participating specialist. Specialists are required to coordinate with the PCP when members need a referral to another specialist. The specialist is responsible for verifying member eligibility prior to providing services.

When a specialist refers the member to a different specialist or provider, then the original specialist must share these records, upon request, with the appropriate provider or specialist. The sharing of the documentation should occur with no cost to the member, other specialists, or other providers.

Primary Care Providers (PCPs) should only refer members to Aetna Better Health of Louisiana network specialists. If the member requires specialized care from a provider outside of our network, a prior authorization is required.

Finding a Specialist
Providers may locate specialists, hospitals, and other providers for member care by contacting their assigned Provider Experience Manager for assistance in finding specialists who can address specific enrollee needs while also considering availability, ratio, distance, and appointment times, as required by the Louisiana Department of Health.

Our experienced, knowledgeable, provider experience staff will respond to inquiries as soon as possible, except for emergency cases, giving providers real-time access to a specialist. You can find contact information for your Provider Experience representative at **AetnaBetterHealth.com/Louisiana/Providers.**

Additionally, the Aetna Better Health of Louisiana provider directory is available online at **AetnaBetterHealth.com/Louisiana**.

Specialty Providers Acting as PCPs
In limited situations, a member may select a physician specialist to serve as their PCP. In these instances, the specialist must be able to demonstrate the ability to provide comprehensive primary care. A specialist may be requested to serve as a PCP under the following conditions:

- When the member has a complex, chronic health condition that requires a specialist's care over a prolonged period and exceeds the capacity of the nonspecialist PCP (i.e., members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis etc.)
- When a member's health condition is life threatening or so degenerative and disabling in nature to warrant a specialist serve in the PCP role.
- In unique situations where terminating the clinician-member relationship would leave the member without access to proper care or services or would end a therapeutic relationship that has been developed over time leaving the member vulnerable or at risk for not receiving proper care or services.

Aetna Better Health of Louisiana's Chief Medical Officer (CMO) will coordinate efforts to review the request for a specialist to serve as PCP. The CMO will have the authority to make the final decision to grant PCP status taking into consideration the conditions noted above.

Specialty providers acting as PCPs must comply with the appointment, telephone, and after-hours standards noted in **Provider Enrollment, Responsibilities, and Important Info**. This includes arranging for coverage 24 hours a day, 7 days a week.

Durable Medical Equipment (DME) Providers

DME providers must be enrolled in the Louisiana Medicaid program to participate. Please see the PROVIDER ENROLLMENT section of this chapter for details. To enroll as a Medicaid provider, a DME and medical supply entity must meet the following criteria:

1. Be licensed by the local government agency as a business or merchant, or provide documentation from the city or county authority that no licensure is required;
2. Be licensed by the Department of Health, Medical Quality Assurance, Board of Orthotics and Prosthetics, if providing orthotics and prosthetic devices;
3. Be licensed by the Agency for Health Care Administration, Division of Health Quality Assurance, in possession of a home health equipment license;
4. Be in compliance with all applicable laws relating to qualifications or licensure; and
5. Have an in-state business location or be located not more than fifty (50) miles from the Louisiana state line.

Self-Referrals/Direct Access

Members may self-refer/directly access some services without an authorization from their PCP. These services include behavioral health care, vision care, adult dental care, family planning, and services provided by Women's Health Care Providers (WHCPs). The member must obtain these self-referred services from an Aetna Better Health of Louisiana provider.

Family planning services do not require prior authorization. Members may access family planning services from any qualified provider (note: It can be par or non-par; we do not restrict family planning services). Members also have direct access to WHCP services. Members have the right to select their own WHCP, including nurse midwives who participate in Aetna Better Health of Louisiana's network, and can obtain maternity and gynecological care without prior approval from a PCP.

Skilled Nursing Facility (SNF) Providers

Nursing Facilities (NF), Skilled Nursing Facilities (SNFs), or Nursing Homes provide services to members that need consistent care, but do not have the need to be hospitalized or require daily care from a physician. Many SNFs provide additional services or other levels of care to meet the special needs of members. Currently skilled nursing services are only preformed during home health services and should not be a covered service any other time.

Out of Network Providers

When a member with a special need or services is not able to be served through a contracted provider, Aetna Better Health of Louisiana will authorize service through an out-of-network provider agreement. Our Medical Management team will arrange care by authorizing services to an out-of-network provider and facilitating transportation through our medical transportation vendor when there are no providers that can meet the member's special need available in a nearby location. If needed, our Provider Experience Department will negotiate a Single Case Agreement (SCA) for the service and refer the provider to our Network Development team for recruitment to join the provider network. The member may be transitioned to a network provider when the treatment or service has been completed or the member's condition is stable enough to allow a transfer of care.

Aetna Better Health of Louisiana will ensure the adherence to Medicaid law, which requires out-of-network practitioners to coordinate with the organization with respect to payment and ensure that the cost to members is no greater than it would be if the services were furnished in network.

Please note: Per Aetna Better Health, a provider is considered out of network while going through the contracting and credentialing process. This includes new provider groups, new individual providers and new providers joining existing groups.

Second Opinions

A member may request a second opinion from a provider within our network. Providers should refer the member to another network provider within an applicable specialty for the second opinion. Please note that there are no timeframes for referrals. If an Aetna Better Health of Louisiana provider is not available, Aetna Better Health will help the member get a second opinion from a non-participating provider at no cost to the member.

Provider Requested Member Transfer

When persistent problems prevent an effective provider-patient relationship, a participating provider may ask an Aetna Better Health of Louisiana member to leave their practice. Such requests cannot be based solely on the member filing a grievance, an appeal, a request for a Fair Hearing or other action by the patient related to coverage, high utilization of resources by the patient or any reason that is not permissible under applicable law.

The following steps must be taken when requesting a specific provider-patient relationship termination:

1. The provider must send a letter informing the member of the termination and the reason(s) for the termination. A copy of this letter must also be sent to:
   Aetna Better Health
   Provider Experience Manager
   2400 Veterans Memorial Blvd., Suite 200
   Kenner, LA 70062
2. The provider must support continuity of care for the member by giving sufficient notice and opportunity to make other arrangements for care.
3. Upon request, the provider will provide resources or recommendations to the member to help locate another participating provider and offer to transfer records to the new provider upon receipt of a signed patient authorization.

In the case of a PCP, Aetna Better Health of Louisiana will work with the member to inform him/her on how to select another primary care provider.

Medical Records Review

Aetna Better Health of Louisiana's standards for medical records have been adopted from the National Committee for Quality Assurance (NCQA) and Medicaid Managed Care Quality Assurance Reform Initiative (QARI). These are the minimum acceptable standards within the Aetna Better Health of Louisiana provider network. Below is a list of Aetna Better Health of Louisiana medical record review criteria. Consistent organization and documentation in patient medical records is required as a component of the Aetna Better Health of Louisiana Quality Management (QM) initiatives to maintain continuity and effective, quality patient care.

Provider records must be maintained in a legible, current, organized, and detailed manner that permits effective patient care and quality review. Providers must make records pertaining to Aetna Better Health of Louisiana members immediately and completely available for review and copying by the Department and federal officials at the provider's place of business, or forward copies of records to the Department upon written request without charge.

Medical records must reflect the different aspects of patient care, including ancillary services. The member's medical record must be legible, organized in a consistent manner and must remain confidential and accessible to authorized persons only.

All medical records, where applicable and required by regulatory agencies, must be made available electronically.

All providers must adhere to national medical record documentation standards. Below are the minimum medical record documentation and coordination requirements:

- Member identification information on each page of the medical record (i.e., name, Medicaid Identification Number)
- Documentation of identifying demographics including the member's name, address, telephone number, employer, Medicaid Identification Number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative

- Complying with all applicable laws and regulations pertaining to the confidentiality of member medical records, including, but not limited to obtaining any required written member consents to disclose confidential medical records for complaint and appeal reviews
- Initial history for the member that includes family medical history, social history, operations, illnesses, accidents, and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member)
- Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance use, allergies and adverse reactions to medications, hospitalizations, surgeries, and emergent/urgent care received
- Immunization records (recommended for adult members if available)
- Dental history if available, and current dental needs and services
- Current problem list (The record will contain a working diagnosis, as well as a final diagnosis and the elements of a history and physical examination, upon which the current diagnosis is based. In addition, significant illness, medical conditions, and health maintenance concerns are identified in the medical record.)
- Patient visit data – Documentation of individual encounters must provide adequate evidence of, at a minimum:
    - History and physical examination – Appropriate subjective and objective information is obtained for the presenting complaints
    - Plan of treatment
    - Diagnostic tests
    - Therapies and other prescribed regimens
    - Follow-up – Encounter forms or notes have a notation, when indicated, concerning follow-up care, call, or visit. Specific time to return is noted in weeks, months, or as needed. Unresolved problems from previous visits are addressed in subsequent visits
    - Referrals, recommendations for specialty, behavioral health, dental and vision care, and results thereof
    - Other aspects of patient care, including ancillary services
- Fiscal records – Providers will retain fiscal records relating to services they have rendered to members, regardless of whether the records have been produced manually or by computer
- Recommendations for specialty care, as well as behavioral health, dental and vision care, and results thereof
- Current medications (Therapies, medications, and other prescribed regimens – Drugs prescribed as part of the treatment, including quantities and dosages, will be entered into the record. If a prescription is telephoned to a pharmacist, the prescriber's record will have a notation to the effect.)
- Documentation, initialed by the member's PCP, to signify review of:
    - Diagnostic information including:
        - Laboratory tests and screenings;
        - Radiology reports;
        - Physical examination notes; and
        - Other pertinent data
- Reports from referrals, consultations, and specialists
- Emergency/urgent care reports
- Hospital discharge summaries (Discharge summaries are included as part of the medical record for (1) hospital admissions that occur while the patient is enrolled in Aetna Better Health of Louisiana and (2) prior admissions as necessary.)
- Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed, and behavioral health history
- Documentation as to whether or not an adult member has completed advance directives and location of the document (Louisiana advance directives include Living Will, Health Care Power of Attorney, and Mental Health Treatment Declaration Preferences and are written instructions relating to the provision of health care when the individual is incapacitated.)
- Documentation related to requests for release of information and subsequent releases,
- Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care

- Entries – Entries will be signed and dated by the responsible licensed provider. The responsible licensed provider will countersign care rendered by ancillary personnel. Alterations of the record will be signed and dated
- Provider identification – Entries are identified as to author
- Legibility – Again, the record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
- Sterilization Consent form

Medical Record Audits

Aetna Better Health of Louisiana, LDH or its appointed authority, or CMS may conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when we are responding to an inquiry on behalf of a member or provider, administrative responsibilities, or quality of care issues. Providers must respond to these requests promptly within thirty (30) days of request. Medical records must be made available to LDH for quality review upon request and free of charge.

Access to Facilities and Records

Providers are required to retain and make available all records pertaining to any aspect of services furnished to a member or their contract with Aetna Better Health of Louisiana for inspection, evaluation, and audit for the longer of:

- A period of five (5) years from the date of service; or
- Three (3) years after final payment is made under the provider's agreement and all pending matters are closed.

Documenting Member Appointments

When scheduling an appointment with a member over the telephone or in person (i.e., when a member appears at your office without an appointment), providers must verify eligibility and document the member's information in the member's medical record. You may access our website to electronically verify member eligibility or call the Member Services Department at **1-855-242-0802**.

Missed or Cancelled Appointments

Providers must:

- Document in the member's medical record, and follow-up on missed or canceled appointments, including missed EPSDT appointments.
- Conducting affirmative outreach to a member who misses an appointment by performing the minimum reasonable efforts to contact the member in order to bring the member's care into compliance with the standards
- Notify our Member Services Department when a member continually misses appointments.

Documenting Referrals

Providers are responsible for initiating, coordinating, and documenting referrals to specialists, including dentists and behavioral health specialists within our network. Providers must follow the respective practices for emergency room care, second opinion, and noncompliant members.

Confidentiality and Accuracy of Member Records

Providers must safeguard/secure the privacy and confidentiality of and verify the accuracy of any information that identifies an Aetna Better Health of Louisiana member. Original medical records must be released only in accordance with federal or state laws, court orders, or subpoenas.

Specifically, our network providers must:

- Maintain accurate medical records and other health information.
- Help verify timely access by members to their medical records and other health information.
- Abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records, other health information, and member information.

Provider must follow both required and voluntary provision of medical records must be consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations **(http://www.hhs.gov/ocr/privacy/**).

Health Insurance Portability and Accountability Act of 1997 (HIPAA)

The Health Insurance Portability and Accountability Act of 1997 (HIPAA) has many provisions affecting the health care industry, including transaction code sets, privacy, and security provisions. The Health Insurance Portability and Accountability Act (HIPAA) impacts what is referred to as covered entities; specifically, providers, health plans, and health care clearinghouses that transmit health care information electronically. The Health Insurance Portability and Accountability Act (HIPAA) have established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit **http://www.hhs.gov/ocr/hipaa/**. In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records, confidential provider, and member information, whether oral or written in any form or medium. To help safeguard patient information, we recommend the following:

- Train your staff on HIPAA;
- Consider the patient sign-in sheet;
- Keep patient records, papers and computer monitors out of view; and
- Have electric shredder or locked shred bins available.

The following member information is considered confidential:

- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information Protected Health Information (PHI). The Privacy Rule, which is a federal regulation, excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.
- "Individually identifiable health information" is information, including demographic data, that relates to:
    - The individual's past, present or future physical or mental health, or condition.
    - The provision of health care to the individual
    - The past, present, or future payment for the provision of health care to the individual and information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
    - Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).
    - Providers' offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Aetna Better Health of Louisiana.
    - Release of data to third parties requires advance written approval from the Department, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by members or releases required by court order, subpoena, or law.

Additional privacy requirements are located throughout this Manual. Please review the "Medical Records" section for additional details surrounding safeguarding patient medical records.

For additional training or Q&A, please visit the following site at **http://aspe.hhs.gov/admnsimp/final/pvcguide1.htm.**

Member Privacy Rights

Aetna Better Health of Louisiana's privacy policy states that members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements. Our privacy policy conforms with 45 C.F.R. (Code of Federal Regulations): relevant sections of the HIPAA that provide

member privacy rights and place restrictions on uses and disclosures of protected health information (§164.520, 522, 524, 526, and 528).

Our policy also assists Aetna Better Health of Louisiana personnel and providers in meeting the privacy requirements of HIPAA when members or authorized representatives exercise privacy rights through privacy request, including:

- Making information available to members or their representatives about Aetna Better Health of Louisiana's practices regarding their PHI
- Maintaining a process for members to request access to, changes to, or restrictions on disclosure of their PHI
- Providing consistent review, disposition, and response to privacy requests within required time standards
- Documenting requests and actions taken.

Member Privacy Requests

Members may make the following requests related to their PHI ("privacy requests") in accordance with federal, state, and local law:

- Make a privacy complaint
- Receive a copy of all or part of the designated record set
- Amend records containing PHI
- Receive an accounting of health plan disclosures of PHI
- Restrict the use and disclosure of PHI
- Receive confidential communications
- Receive a Notice of Privacy Practices

A privacy request must be submitted by the member or member's authorized representative. A member's representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the member or the deceased member's estate. Except for requests for a health plan Notice of Privacy Practices, requests from members or a member's representative must be submitted to Aetna Better Health of Louisiana in writing.

Health Equity/ Cultural Competency

Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

"**Equity** is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification." - *World*

Health Organization

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." -Robert Wood Johnson Foundation

Everyone has the opportunity to live their best life!

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. Aetna Better Health of Louisiana expects providers to treat all members with dignity and respect as required by federal law including honoring member's beliefs, be sensitive to cultural diversity, and foster respect for member's cultural backgrounds. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

Aetna Better Health of Louisiana has developed effective provider education programs that encourage respect for diversity, foster skills that facilitate communication within different cultural groups and explain the relationship between cultural competency and health outcomes. These programs provide information on our members' diverse

backgrounds, including the various cultural, racial, and linguistic challenges that members encounter, and we develop and implement proven methods for responding to those challenges.

Providers receive education about such important topics as:

- The reluctance of certain cultures to discuss mental health issues and of the need to proactively encourage members from such backgrounds to seek needed treatment
- The impact that a member's religious and cultural beliefs can have on health outcomes (e.g., belief in non-traditional healing practices).
- The problem of health illiteracy and the need to provide patients with understandable health information (e.g., simple diagrams, communicating in the vernacular, etc.)
- History of the disability rights movement and the progression of civil rights for people with disabilities.
- Physical and programmatic barriers that impact people with disabilities accessing meaningful care

Initial cultural competency training is included in provider orientation materials. The *Quality Interactions*® course series is designed to help you:

- Bridge cultures
- Build stronger patient relationships
- Provide more effective care to ethnic and minority patients
- Work with your patients to help obtain better health outcomes

Providers are required annually to access and complete the online cultural competency course, please visit: **aetna.com/healthcare-professionals/training-education/cultural-competency-courses.html**

To increase health literacy, the National Patient Safety Foundation created the Ask Me 3™ Program. Aetna Better Health of Louisiana supports the Ask Me 3™ Program, as it is an effective tool designed to improve health communication between members and providers.

Health Literacy – Limited English Proficiency (LEP) or Reading Skills

In accordance with Title VI of the 1964 Civil Rights Act, national standards for culturally and linguistically appropriate health care services and State requirements, Aetna Better Health of Louisiana is required to verify that Limited English Proficient (LEP) members have meaningful access to health care services. Because of language differences and inability to speak or understand English, LEP persons are often excluded from programs they are eligible for, experience delays or denials of services or receive care and services based on inaccurate or incomplete information.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. Providers are required to treat all members with dignity and respect, in accordance with federal law. Providers must deliver services in a culturally effective manner to all members, including:

- Those with limited English proficiency (LEP) or reading skills
- Those with diverse cultural and ethnic backgrounds
- The homeless
- Individuals with physical and mental disabilities

Providers are required to identify the language needs of members and to provide oral translation, oral interpretation, and sign language services to members. To assist providers with this, Aetna Better Health of Louisiana makes its telephonic language interpretation service available to providers to facilitate member interactions. These services are free to the member and to the provider. However, if the provider chooses to use another resource for interpretation services, the provider is financially responsible to associated costs.

Our language interpreter vendor provides interpreter services at no cost to providers and members.

Language interpretation services are available for use in the following scenarios:

- If a member requests interpretation services, Aetna Better Health of Louisiana Member Services Representatives will assist the member via a three-way call to communicate in the member's native language.

- For outgoing calls, Member Services Staff dial the language interpretation service and use an interactive voice response system to conference with a member and the interpreter.
- For face-to-face meetings, Aetna Better Health of Louisiana staff (e.g., Case Managers) can conference in an interpreter to communicate with a member in his or her home or another location.
- When providers need interpreter services and cannot access them from their office, they can call Aetna Better Health of Louisiana to link with an interpreter.

Aetna Better Health of Louisiana provides alternative methods of communication for members who are visually impaired, including large print and other formats. Contact our Member Services Department for alternative formats.

We strongly recommend the use of professional interpreters, rather than family or friends. Further, we provide member materials in other formats to meet specific member needs. Providers must also deliver information in a manner that is understood by the member.

Aetna Better Health of Louisiana offers sign language and over-the-phone interpreter services at no cost to the provider or member. Please contact Aetna Better Health of Louisiana at **1-855-242-0802** for more information on how to schedule these services in advance of an appointment.

Individuals with Disabilities
Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician's office, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. Regular provider office will be conducted by our Provider Experience staff to verify that network providers are compliant.

Clinical Guidelines
Aetna Better Health of Louisiana has Clinical Guidelines and treatment protocols available to provider to help identify criteria for appropriate and effective use of health care services and consistency in the care provided to members and the general community. These guidelines are not intended to:
- Supplant the duty of a qualified health professional to provide treatment based on the individual needs of the member;
- Constitute procedures for or the practice of medicine by the party distributing the guidelines; or
- Guarantee coverage or payment for the type or level of care proposed or provided.

Clinical Guidelines are available on our website at **AetnaBetterHealth.com/Louisiana.**

Office Administration Changes and Training
Providers are responsible to notify our Provider Experience Department on any changes in professional staff at their offices (physicians, physician assistants, or nurse practitioners). Administrative changes in office staff may result in the need for additional training. Contact our Provider Experience Department to schedule staff training.

Continuity of Care
Providers terminating their contracts are required to provide a notice before terminating with Aetna Better Health of Louisiana. Provider must also continue to treat our members until the treatment course has been completed or care is transitioned. An authorization may be necessary for these services. Members who lose eligibility and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost. Aetna Better Health of Louisiana is not responsible for payment of services rendered to members who are not eligible. You may also contact our Care Management Department for assistance.

Credentialing/Re-Credentialing
Aetna Better Health of Louisiana uses current NCQA standards and guidelines for the review, credentialing and re-credentialing of providers and uses the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource for all provider types. The Universal Credentialing DataSource was developed by America's leading health

plans collaborating through CAQH. The Universal Credentialing DataSource is the leading industry-wide service to address one of providers' most redundant administrative tasks: the credentialing application process.

The Universal Credentialing DataSource Program allows providers to use a standard application and a common database to submit one application, to one source, and update it on a quarterly basis to meet the needs of all of the health plans and hospitals participating in the CAQH effort. Health plans and hospitals designated by the providers obtain the application information directly from the database, eliminating the need to have multiple organizations contacting the provider for the same standard information. Providers update their information on a quarterly basis to verify data is maintained in a constant state of readiness. CAQH gathers and stores detailed data from more than 600,000 providers nationwide. All new providers, unless otherwise exempt, including providers joining an existing participating practice with Aetna Better Health of Louisiana, must complete the credentialing process and be approved by the Credentialing Committee. The following providers will be exempt from ABHLA's credentialling process:

- 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
- Any provider who is a member of the medical staff of a RHC licensed in accordance with R.S. 2197 et seq
- Any provider who is a member of the medical staff of a FQHC as defined in R.S. 40:1185.3

Providers are re-credentialed every three years and must complete the required reappointment application. Updates on malpractice coverage, state medical licenses, and DEA certificates are also required.

Aetna Better Health shall provide a minimum of three written notices to a contracted provider with information regarding the re-credentialing process, including requirements and deadlines for compliance. The first notice shall be issued no later than six months prior to the expiration of the provider's current credentialing. The notice shall include the effective date of termination if the provider fails to meet the requirements and deadlines of the re-credentialing process. Aetna Better Health shall send the written notices required to the last mailing address and last email address submitted by the provider.

Please note: Credentialing and contracting are separate and distinct processes; therefore, the credentialing notification does not serve as the practitioner's notice of participation or participation effective date.
ABHLA will completely process all credentialing applications within 60 days of receiving a clean contracting and credentialing packet (applications that include all necessary documentation and attachments and a signed provider agreement). This includes: providing written confirmation to the provider within 5 business days of receipt; review, approval, and loading of applicants into the ABHLA claims processing system, inclusion of the provider in the weekly submission of the electronic provider directory to LDH; or denial of the application Providers will be notified within 30 days if their application is deemed to be incorrect or incomplete. This process applies to new provider groups, new individual providers and new providers joining existing groups.

Licensure and Accreditation

Health delivery organizations such as hospitals, skilled nursing facilities, home health agencies, Therapeutic Group Homes, Psychiatric Residential Treatment Facilities, Substance Use Residential Facilities, Crisis Stabilization, Crisis Response providers, Mental Health Rehabilitation agencies, Opioid Treatment Programs, and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as indicated.

Discrimination Laws

Providers are subject to all laws applicable to recipients of federal funds, including, without limitation:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84
- The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91
- The Rehabilitation Act of 1973
- The Americans with Disabilities Act
- Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law
- The False Claims Act (31 U.S.C. §§ 3729 et. seq.)
- The Anti-Kickback Statute (section 1128B(b) of the Social Security Act)

- HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164

In addition, our network providers must comply with all applicable laws, rules, and regulations, and, as provided in applicable laws, rules and regulations, network providers are prohibited from discriminating against any member on the basis of health status.

Financial Liability for Payment for Services

In no event should a provider bill a member (or a person acting on behalf of a member) for payment of fees that are the legal obligation of Aetna Better Health of Louisiana. However, a network provider may collect monies from members in accordance with the terms of the member's Handbook (if applicable). Providers must make certain that they are:

- Agreeing not to hold members liable for payment of any fees that are the legal obligation of Aetna Better Health of Louisiana, and must indemnify the member for payment of any fees that are the legal obligation of Aetna Better Health of Louisiana for services furnished by providers that have been authorized by Aetna to service such members, as long as the member follows Aetna's rules for accessing services described in the approved Member Handbook.
- Agreeing not to bill a member for medically necessary services covered under the plan and to always notify members prior to rendering services.
- Agreeing to clearly advise a member, prior to furnishing a non-covered service, of the member's responsibility to pay the full cost of the services
- Agreeing that when referring a member to another provider for a non-covered service must verify that the member is aware of his or her obligation to pay in full for such non-covered services.

Continuity of Care for Pregnant Women

Members should be held harmless by the provider for the costs of medically necessary core benefits and services.

In the event a Medicaid eligible entering Aetna Better Health of Louisiana is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before Aetna Better Health of Louisiana enrollment, Aetna Better Health of Louisiana will be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider until such time as Aetna Better Health of Louisiana can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health.

In the event a member entering the health plan is in her second or third trimester of pregnancy and is receiving medically-necessary covered prenatal care services the day before enrollment, Aetna Better Health will be responsible for providing continued access to the prenatal care provider (whether contract or noncontract provider) for sixty (60) days post-partum, provided the member is still eligible for Medicaid, or referral to a safety net provider if the member's eligibility terminates before the end of the post-partum period.

Continuity for Behavioral Health Care

The PCP will provide basic behavioral health services and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.

Provider Marketing

All health care providers delivering services to Aetna Better Health of Louisiana members enrolled in Healthy Louisiana plans are welcome to inform their patients of the Healthy Louisiana Plan they have chosen to participate with, but Healthy Louisiana has strict prohibitions against patient steering, which all providers must observe. The requirements below must be strictly observed by all Healthy Louisiana providers.

- Providers may inform their patients of all Healthy Louisiana Plans in which they participate, and can inform patients of the benefits, services, and specialty care services offered through the Healthy Louisiana Plan in which they participate.
- **Providers are not allowed to disclose only some of the Healthy Louisiana Plans in which they participate**. Disclosure of Healthy Louisiana Plan participation must be all or nothing.

- Providers can display signage, provided by the Healthy Louisiana Plan, at their location indicating which Healthy Louisiana Plans are accepted there, but must include all Healthy Louisiana Plans in which they participate in this signage.
- If a provider participates in only one Healthy Louisiana Plan, the provider can display signage for only one and can tell a patient that is the only Healthy Louisiana Plan accepted by that provider.
- Providers **MAY NOT RECOMMEND** one Healthy Louisiana Plan over another Healthy Louisiana Plan and **MAY NOT OFFER** patients incentives for selecting one Healthy Louisiana Plan over another.
- Providers **MAY NOT ASSIST** a patient in the selection of a specific Healthy Louisiana Plan. Additionally, patients may not use the provider's fax machine, office phone, computer, etc., to make such a selection, except as required for the completion of a Medicaid application as a function of being an enrolled Medicaid Application Center.
- Patients who need assistance with their Health Plan services should call the Member Services Hotline for the Plan in which they are enrolled, and those who wish to learn more about the different Healthy Louisiana Plans should contact the Healthy Louisiana Enrollment Broker at **1-855-229-6848** to receive assistance in making a Healthy Louisiana Plan decision.
- Under **NO CIRCUMSTANCES** is a provider allowed to change a member's Healthy Louisiana Plan for him/her, or request a Healthy Louisiana Plan reassignment on a member's behalf. **Members who wish to change their Healthy Louisiana Plan for cause must make this request to Medicaid themselves through the Healthy Louisiana Enrollment Broker.**

These prohibitions against patient steering apply to participation in the Healthy Louisiana programs.
If a provider or Health Plan is found to have engaged in-patient steering, they may be subject to sanctions such as, but not limited to monetary penalties, loss of linked patients and excluded from enrollment in Medicaid/Healthy Louisiana Plan network opportunities.

LDH Service Definitions Manual

Louisiana LDH Service Definitions Manual is available for providers upon request. To access online, please follow the link below:

https://www.lamedicaid.com/Provweb1/Providermanuals/ProviderManuals.htm

Services covered by Aetna Better Health of Louisiana are listed below. Some limitations and prior authorization requirements may apply.

All services must be medically necessary. If you have questions about covered services, call Member Services at **1-855-242-0802,** TTY **711**. For specific criteria and prior authorization requirements, please see the Utilization Management section of the ABHLA provider website.

Behavioral Health Services are highlighted

Service/Benefit	Covered Service/Benefit	Limits
Allergy Testing and Immunotherapy	Allergy testing and immunotherapy relating to hypersensitivity disorders and for patients who have symptoms of allergic disease are covered.	Prior authorization is not required, but coverage limitations do apply.
Applied Behavior Analysis (ABA)	Behavior analysis is based on a scientific study of how people learn. By doing research, techniques have been developed that increase useful behavior (including communication) and reduce harmful behavior.	Covered for members from age 0-20. Prior authorization is required.
Basic behavioral health services	Services are provided in a primary care clinic and include screening for mental health and substance use issues, prevention, early intervention, medication management, treatment, and referral to specialty services.	Not limited by Aetna Better Health of Louisiana
Bariatric Surgery	Bariatric surgery is covered when determined to be medically necessary	Prior authorization is required. See UM Criteria page on ABHLA provider website for details.
Behavioral Health Home and Community Based Services-Adults	Assistance and support provided at home, school, or work. Additional services may be available for members with special mental health care needs. Includes Assertive Community Treatment (ACT), Crisis Intervention (CI), Community Psychiatric Support and Treatment (CPST), and Psychosocial Rehabilitation (PSR).	Covered for members eligible for adult mental health rehabilitation services. Prior authorization is required with the exception of emergent crisis intervention (CI).
Behavioral Health Home and Community Based Services-Children and Adolescents	Assistance and support provided at home, school, or work. Additional services may be available for members with special mental health care needs. Includes Assertive Community Treatment (ACT), Crisis Intervention (CI), Functional Family Therapy (FFT), Homebuilders, Multi-systemic Therapy (MST), Community Psychiatric Support and Treatment (CPST), and Psychosocial Rehabilitation (PSR).	Covered for members from age 0-20. Age for specific services varies. Prior authorization is required with the exception of emergent crisis intervention (CI)

Service/Benefit	Covered Service/Benefit	Limits
Breast Pump	Covered for expectant mothers at 32 weeks gestational age who meet eligibility criteria	Prior authorization is not required. Providers must submit Electric Breast Pump Request Form with claim
Breast Surgery	Risk-reducing mastectomy and breast conserving surgery is covered when it is determined to be medically necessary.	Prior authorization is required (simple mastectomy is covered without prior authorization when determined to be medically necessary).
Cardiovascular Services	Elective Invasive Coronary Angiography (ICA) and Percutaneous Coronary Intervention (PCI) is covered when determined to be medically necessary.	For members 18 and over when medically necessary. For eligibility criteria, see Cardiovascular Services. Excludes members who are: under the age of 18; pregnant; cardiac transplant enrollees; solid organ transplant candidates; and survivors of sudden cardiac arrest.
Cervical Cancer Screening	Covered for members 21 and over. Covered for members under 21 when medically necessary: • were exposed to diethylstilbestrol before birth; • have Human Immunodeficiency Virus; • have a weakened immune system; • have a history of cervical cancer or abnormal cervical cancer screening test; or • meet other criteria subsequently published by ACOG. Providers of beneficiaries meeting the any of the criteria above must submit hard copy supporting documentation to the fiscal intermediary. This includes but is not limited to: Initial abnormal Pap test result and subsequent abnormal Pap test results; History and Physical; Procedure note.	
Chiropractic services	Medically necessary Chiropractic services when the service is provided as a result of a referral from an EPSDT medical screening provider or Primary Care Provider (PCP).	Covered for members of all ages, including 18 visits for adults aged 21+ as an in lieu of benefit. See *In Lieu of Services*.

Service/Benefit	Covered Service/Benefit	Limits
Cochlear implants	Includes: • Pre-operative speech and language evaluation • Implants, equipment, repairs, and replacements • Implantation procedure • Post-operative rehabilitative costs • Subsequent therapy (speech, language, hearing) • Re-performance of implantation surgery • Post-operative programming	Covered for members from age 0-20. Prior authorization required for all aspects of cochlear care. For more information, see Cochlear Implants.
Corneal Collagen Cross-Linking (CXL)	Medically necessary CXL and riboflavin 5'-phosphate, ophthalmic solution up to 3mL	Covered for members aged 14-20 with progressive keratoconus. Prior authorization is required.
Continual Glucose Monitoring Device	Covered through the durable medical equipment benefit for members who meet certain criteria	Prior authorization is required.
Community Health Workers	Includes: • Health promotion and coaching • Care planning • Health system navigation Additional requirements for CHW in Federally Qualified Health Centers and Rural Health Clinics	Covered for members with one or more of the following: • Diagnosis of one or more chronic health condition • Suspected/documented unmet health-related social need • Pregnancy
Crisis Response Services	Crisis resolution and support provided in the community available right away, twenty-four hours a day, seven days a week. Includes Mobile Crisis Response (MCR), Behavioral Health Crisis Care (BHCC), and Community Brief Crisis Support (CBCS).	MCR and CBCS are covered for all ages. BHCC is covered for members from age 21 and up. Prior authorization required for CBCS. A follow up is required within 24 hours.
Crisis Stabilization (Adult)	Short term, intensive, bed-based crisis support	Prior authorization is required. Members admitted to this level of care should be medically stable. Members who have a co-morbid physical condition that requires nursing or hospital level of care or who are a threat to themselves or others and require an inpatient level of care are not eligible.
Crisis Stabilization (Youth)	Short term, intensive, bed-based crisis support	Prior authorization is required.
Dental	After the first visit, you should see your dentist every six months.	Members 21 and over: Up to $1,000 per year towards dental care, including preventative services

Service/Benefit	Covered Service/Benefit	Limits
Developmental and Autism Screening	Developmental and autism screenings administered during EPSDT preventive visits in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule	The plan will only reimburse the use of age-appropriate, caregiver-completed, and validated screening tools as recommended by the AAP. If a positive screening on a developmental or autism screen, the provider must give appropriate developmental health recommendations, refer the member 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 members 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 2 units of the relevant procedure code.
Dialysis	Hemodialysis and peritoneal dialysis are covered for the treatment of End Stage Renal Disease (ESRD).	Prior authorization is required.
Disposable Incontinent Supplies	Covered for children ages 4-20 years old and adult members with the Home and Community Based Services Waiver (HCBS)	Prior authorization is required. Limit eight per day. See **full policy** for details
Disposable (Elastomeric) Infusion Pump	Covered for short term use (less than 30 days) for antibiotic infusion therapy	Prior authorization is required.
Durable Medical Equipment	Medical equipment, appliances, and supplies such as wheelchairs, bed rails, walkers, and crutches	Prior authorization is required.
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	Auditory osseointegrated device and supplies, cough stimulating device, hearing aids, pediatric hospital bed, standing frame/table system covered for age 20 and younger.	Not covered for Members 21 years of age or older.
Early Periodic Screening, Diagnostic, and Treatment (EPSDT)/Well-Child Checkups	• Medical screenings • Developmental screenings • Vision screenings • Hearing screenings • Dental screenings	Covered for members age 0-20

Service/Benefit	Covered Service/Benefit	Limits
	• Periodic and inter-periodic Screenings	
	School-Based Medical Program personal care services, which may include the following, depending on need: • Grooming • Eating • Transfers • Mobility • Positioning • Toileting • Behavioral cuing	Covered for members aged 0-20 in a school setting, when ordered by a licensed practitioner within the scope of their practice and the student is dependent in, and need assistance, for one or more of the activities of daily living (ADL).
Emergency Medical Services	ER (Emergency Room) services	
Emergency Medical Transportation	Ground and air ambulance including rotor- and fixed-wing	
End Stage Renal Disease Services (Dialysis)	Dialysis treatment (including routine laboratory services), medically necessary non-routine lab services, and medically necessary injections	
Enteral formula	Covered for beneficiaries who require formula to fulfill at least 70% of their caloric need.	For members of the Office of Public Health (OPH) Genetic Diseases Program, no PA is required. For all other patients, prior authorization is required.
Enteral Infusion Pump	Covered for members with one of the following conditions: • designated as “terminally ill” by a physician • Inborn errors of metabolism • Intellectual disability • Failure to thrive	Prior authorization is required.
Family planning services	May obtain services in or out of network (no cost for out of network family planning) including: Seven evaluation and management office visits per year for physical examinations for both males and females as it relates to family planning or family planning-related services;	Elective abortions are not covered.

Service/Benefit	Covered Service/Benefit	Limits
	Contraceptive counseling (including natural family planning), education, follow-ups, and referrals; Laboratory procedures for the purposes of family planning and management of sexual health; Pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the Federal Food and Drug Administration; and Male and female sterilization procedures and follow up tests.	
Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)	Professional medical and basic behavioral health services furnished by doctors (Primary Care Providers), nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists, licensed professional counselors, licensed marriage and family therapists, physicians with psychiatric specialties, and dentists.	Not limited by Aetna Better Health of Louisiana
Gender Affirming Care	Prior authorization is required for all requests related to gender affirming care, surgery, or treatment including diagnosis codes F64.0-F64.9 & Z87.890	Not covered for members under age 18
Genetic Counseling	Required before and after all genetic testing. Reimbursed when performed by licensed genetic counselors using the procedure code 96040.	Covered for members aged 0-99. Maximum units = 3.
Genetic Testing	Testing for BRCA1 and BRCA2 genetic mutations are covered in cancer-affected and -unaffected individuals meet eligibility requirements. See **Genetic Testing (BRCA1 and BRCA2).**	Not covered for members under age 19
Hearing aids	Hearing aids and related supplies such as earpieces and batteries	Not covered for members over age 21.
Home health services	• Skilled nursing services • Home health aide • Physical, occupational or speech therapy • Home infusion • Wound therapy	Prior authorization is required. Providers must clearly identify the hours per day and days per week requested on the authorization form. Effective January 1, 2024, providers must clock the nursing or therapy hours in the LaSRS EVV system as directed by LDH. A service code reflecting the hours per day and days per week will be loaded with the authorization system into the EVV system for providers to clock. ABHLA must withhold or deny reimbursement for services if a HHC provider fails to utilize the EVV system.

Service/Benefit	Covered Service/Benefit	Limits
	• Extended Home Health (EHH) Services • Extended Skilled Nursing Services • Intermittent Nursing (IN) Services	For members 21+, only one visit per profession per day is covered. Covered for members birth through 20. Plan of Care (POC) and prior authorization are required when medically necessary. See **UM Criteria** page on the ABHLA provider website for details. Daily nursing visits less than 3 hours per day for members under 21 not meeting medical necessity criteria for EHH do not require prior authorization as Intermittent Nursing Services.
Hospice	Care provided by a certified hospice agency for terminally ill members**.** See **Hospice**	Prior authorization is required.
Hospital Bed, Mattress, And Lift	Covered for members with a documented medical need who meet medical necessity criteria. Each type of equipment requires specific documentation. See **UM Criteria** page of the ABHLA provider website for details.	Prior authorization is required
Human Donor Milk Outpatient	Covered for use by medically vulnerable infants when certain criteria are met. See **Human Donor Milk**	Prior authorization is not required, but the service is subject to post payment medical review.
Human Milk Storage Bags	Covered through DME benefit for lactating beneficiaries with the following criteria: • Prescription signed by prescribing physician • Documentation that beneficiary is lactating • 100 bags/month limit	Prior authorization is required
Immunizations	Covered for members 0-20 Covered for members 0-18 via the Vaccines for Children (VFC) Program. Coverage for populations such as waivers programs, children not eligible for VFC, or for vaccines not provided by VFC. Some coverage for members 21 and up including flu, Human Papilloma virus (HPV), tetanus, and Pneumococcal polysaccharide vaccine (PPSV)	Limitations apply depending on member's age.
Individual Placement and Support (IPS)	Supported employment services for members with mental illness	Covered for members transitioned or diverted from nursing facility level of care through the My Choice Louisiana program. Prior authorization is required.

Service/Benefit	Covered Service/Benefit	Limits
Inpatient hospital services	Inpatient hospital care needed for the treatment of an illness or injury that can only be provided safely and adequately in a hospital setting, including those basic services a hospital is expected to provide.	Prior authorization is required.
Intensive Outpatient Treatment (IOP)	Mental health and substance use treatment and recovery services provided in a community setting.	Prior authorization is required. For more information on Mental Health Intensive Outpatient treatment (MH IOP), see *Behavioral Health In Lieu of Services*.
Lab tests and X-rays	Most diagnostic testing and radiological services ordered by the attending or consulting physician.	Prior authorization is required.
	When medically necessary, portable x-rays are covered for recipients who are unable to travel to a physician's office or outpatient hospital's radiology facility. (See Portable X-Ray Claims)	Coverage limited to skeletal films of a recipient's arms, legs, pelvis, vertebral column or skull, chest films which do not involve the use of contrast media, and abdominal films which do not involve the use of contrast media.
Mammograms	Screening mammography, bilateral and Screening digital breast tomosynthesis, bilateral covered for Members aged 30 and up.	Not covered for Members under age 30.
Maternity care services	Prenatal through postpartum, including Obstetrical Ultrasounds, NIPT, and Tobacco Cessation Counseling.	
Mental health Inpatient Hospital Services	Mental health services provided in the hospital	Prior authorization may be required.
Negative Pressure Wound Therapy (NPWT) Pump	One NPWT pump covered per month by any provider.	
Non-Emergency Medical Transportation	Transportation to and from appointments for Medicaid covered services appointments and to extra services we offer such as adult dental care and pharmacy following a visit to your provider.	Services are scheduled through Meditrans Transportation Company and are not limited by Aetna Better Health of Louisiana
Non-invasive Prenatal Testing (NIPT)	NIPT is offered as a service to pregnant women over the age of 35, and to pregnant women of any age who meet one or more of the following high-risk criteria: Abnormal first trimester screen, quad screen, or integrated screen. Abnormal fetal ultrasound scan indicating increased risk of aneuploidy. Prior family history of aneuploidy in first degree relative for either parent. Previous history of pregnancy with aneuploidy.	NIPT is not covered for women with multiple gestations. For dates of service on or after 12/01/2020, CPT Codes 81507 and 81420 do not require prior authorization.

Service/Benefit	Covered Service/Benefit	Limits
	Known Robertsonian translocation in either parent involving chromosomes 13 or 21.	
Nurse midwife and nurse practitioner services	Covered when performed in a doctor's office or clinic	
Nutritional/dietician consult services	Nutritional consultation	Prior authorization is required. Not covered for members over age 21
Obstetrical ultrasounds	All covered OB ultrasounds must be deemed medically necessary. Three (3) medically necessary ultrasounds per pregnancy (270 days) are covered without prior authorization or medical review. If additional studies are needed, prior authorization will be required. The following requirements also apply: • When an obstetric ultrasound is performed for an individual with multiple gestations, leading to more than one procedure code being submitted, this shall 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 shall 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.
Opioid Treatment Programs (OTP)	Medication-assisted treatment for members with documented Opioid Use Disorder	Covered for members of all ages (under age 18 requires guardian consent when applicable). Prior authorization and referral is required.

Service/Benefit	Covered Service/Benefit	Limits
Outpatient Therapy by Licensed Practitioners • **Provisionally Licensed Professional Counselors** • **Provisionally Licensed Marriage and Family Therapists** • **Licensed Master Social Workers** • **Licensed Mental Health Professionals (LMHP) licensed by the State** — **Psychiatrists** — **Licensed Psychologists** — **Medical Psychologists** — **Physician's Assistant** — **Licensed Professional Counselors** — **Licensed Clinical Social Workers** — **Licensed Addiction Counselors** — **Licensed Marriage and Family Therapists** — **Advanced Practice Registered Nurses (psychiatric specialists)**	Outpatient counseling for mental health and substance use treatment	No prior authorization is required
Outpatient services	Diagnostic and therapeutic outpatient services including outpatient surgery and rehabilitation services, therapeutic and diagnostic radiology services, chemotherapy, and hemodialysis These services should be billed to Aetna Better Health in accordance with the Hospital Services Provider Manual.	Prior authorization may be required. Refer to the ABHLA Prior Authorization list or the Hospital Services manual for a list of services that require prior authorization.
Organ transplant and related services	Evaluation, transplant, and facility costs are covered.	Donor costs are not covered. Prior authorization is required.
Oxygen: Portable Oxygen Contents	Covered for beneficiaries with a documented medical need	Prior authorization on a per-month basis is required
Oxygen: Supplemental Oxygen and Oxygen Supplies	Covered for members with a documented medical need who meet medical necessity criteria. See Supplemental Oxygen policy on ABHLA provider website	Prior authorization is required. Prescribing provider must see the member within 60 days of prescribing oxygen therapy.

Service/Benefit	Covered Service/Benefit	Limits
Pediatric Day Healthcare Services (PDHC)	Services include nursing care and assessments, medication administration, wound care, supervised feeding, respiratory care, physical therapy, speech therapy, occupational therapy, assistance with aids of daily living, transportation services, and education and training. Nursing care services and therapy provided in a central location during the day, up to 12 hours per day up to 7 days a week.	Covered for members up to 21 years when medically necessary. Prior authorization is required.
Personal Care Services (PCS)- Behavioral Health	Assistance and supervision for members with mental illness to allow them to complete activities of daily living and live independently.	Covered for members transitioned or diverted from nursing facility level of care through the My Choice Louisiana program. Limit of 20 hours/week. Prior authorization is required.
Personal Care Services (PCS) – Early and Periodic Screening Diagnostic and Treatment (EPSDT) Physical Health	Assistance and supervision for members with physical disabilities to assist with completing activities of daily living and live independently	Prior authorization is required. Providers must submit hours per day and days per week with the authorization request. This is translated to an authorization service code that is loaded into the EVV system. Providers may only clock the hours approved in the request. Hours may not be moved from one day to the next. Providers must clock in the LaSRS EVV system as directed by LDH. ABHLA must withhold or deny reimbursement for services if a PCS provider fails to utilize the EVV system. Providers must be registered with LDH.
Positron Emission Tomography (PET) scans	PET scans (G0219, G0235, G0252, 78608, 78609, 78811-78816) and radiopharmaceutical agents (A9515, A9526, A9552, A9580, A9587, A9588) must be reported with an appropriate diagnosis indicating their medical necessity. The payable revenue codes for positron emission tomography scans are 343 and 404. These revenue codes must be billed with the appropriate accompanying CPT codes.	Claims for PET scans and radiopharmaceutical agents billed without an appropriate diagnosis will be denied.
Peer Support	Support from people with the same experiences. This includes but is not limited to experiences living with a mental illness or substance use disorder or caring for a child with a mental illness or substance use disorder.	Prior authorization is required

Service/Benefit	Covered Service/Benefit	Limits
Perinatal Depression Screening	The plan shall cover perinatal depression screening administered to any member's caregiver in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule.	The screening can be administered from birth to 1 year during an Early and Periodic Screening, If 2 or more children under age 1 present to care on the same day (e.g., twins or other siblings both under age 1), the provider must submit the claim under only one of the children. When performed on the same day as a developmental screening, providers must append modifier -59 to claims for perinatal depression screening.
Pharmacy services	Prescription medications that are on our formulary For a complete list of meds and/or to review the formulary, please visit **www.AetnaBetterHealth.com/Louisiana**.	Quantity limits, step therapy, and prior authorization may be required.
Physician-administered drugs	See **Physician-Administered Drugs and Maximum Units**.	Prior authorization may be required regardless of setting.
Physician/professional services	Professional medical services including those of a physician, nurse midwife, nurse practitioner, clinical nurse specialists or physician assistant.	Prior authorization may be required.
Podiatrist services	Office visits, certain radiology and lab procedures and other diagnostic procedures.	Prior authorization may be required.
Psychiatric Residential Treatment Facilities	Allows youth to live in a treatment facility to get the behavioral health care needed	For members under age 21. Prior authorization is required.
Psychiatrist Visits	Visits with a licensed psychiatrist. A psychiatric nurse practitioner is also able to provide this service.	No prior authorization required
Radiology services	Most diagnostic testing and radiological services ordered by the attending or consulting physician.	Only CT scans and MRI's require prior authorization
Rehabilitation services	Short term stays in a long-term care nursing facility for the purposes of	Prior authorization is required.
Respiratory Viral Panels	CPT codes 87631, 87632, and 87633 are covered	Medical necessity is required. See Respiratory Viral Panels
Substance Use Rehabilitation Services	Outpatient, Inpatient, and residential counseling and treatment for substance use conditions.	Prior authorization may be required.
Sedation services	Moderate (conscious) sedation services are covered for members 20 and under.	Not covered for members aged 21 and over.
Sexually Transmitted Disease (STD) services	Testing, counseling and treatment of all STDs and confidential HIV testing	

Service/Benefit	Covered Service/Benefit	Limits
Sinus procedures	Balloon ostial dilation and functional endoscopic sinus surgeries are covered when certain criteria are met. See coverage criteria in **Sinus Procedures**	Coverage limitations do apply. Reimbursement is subject to post-payment review and recoupment in the event of non-compliance with the coverage policy.
Skin substitutes	Covered for patients with Chronic Diabetic Lower Extremity Ulcers. See coverage criteria in **Skin Substitutes**.	Prior authorization is required Documentation must demonstrate that the beneficiary meets all requirements.
Telemedicine for behavioral health services	An alternative to clinic visits for members that have barriers to in-person behavioral health services. Meet with your behavioral health providers from a computer.	
Sterilization / Hysterectomy	For reimbursement, Sterilization and Hysterectomy procedures require receipt of a state-approved consent form properly executed per state requirements, and on the applicable fee schedule or contracted/negotiated rate. ABHLA allows ancillary providers and hospitals to submit claims without the hard copy consent if the provider performing the sterilization has submitted a valid sterilization consent and was reimbursed for the procedure.	Members must be at least 21 years old at time the consent is obtained, must be a mentally competent individual, who has voluntarily given informed consent in accordance with all federal requirements. At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.
Therapeutic Day Treatment	Provides intensive mental health supports combined with classroom instruction as an alternative to crisis hospitalization and residential psychiatric care for youth with behavioral, emotional, or mental health issues.	For members ages 5-20. Prior authorization is required.
Therapeutic Group Homes	Allows youth to live in a home-like setting with a small group of other youth to get the services needed	For members under age 21. Prior authorization is required.
Therapy services	Occupational, physical, speech, and language	Prior authorization is required. Renewal Therapy request should show progress.

Service/Benefit	Covered Service/Benefit	Limits
Tobacco cessation counseling (including during pregnancy)	Counseling to help Members (including pregnant individuals) quit tobacco use. Must be provided by PCP, OB, or a professional referred by PCP or OB.	Up to 4 sessions per quit attempt Up to 2 quit attempts per calendar year Maximum of 8 sessions/yr Limits may be exceeded if deemed medically necessary Covered during prenatal period through 60 days postpartum for pregnant individuals
Transcranial Magnetic Stimulation (TMS)	Covered for major depression when medically necessary.	Medical necessity is required. See Transcranial Magnetic Stimulation
Urine Drug Screening	Presumptive drug testing is limited to twenty-four (24) total tests per enrollee per calendar year with no more than two (2) in one (1) month. Definitive drug testing is limited to twelve (12) total tests per enrollee per calendar year with no more than one (1) per month. Testing more than fourteen (14) definitive drug classes per day is not reimbursable. No more than one presumptive drug test AND one definitive test are reimbursed per day per enrollee, from the same or different provider.	Limits and stipulations apply. See Urine Drug Screening
Vision services	Adults 21 and over: Your covered services include optometrist services, a free annual eye exam, and $150 toward eyewear (frames, glass, or contact lenses). Members 21 and under: Covered services include: — A comprehensive eye exam interpreted by a licensed network optometrist or ophthalmologist — A preventative vision screening performed by trained staff under the supervision of a licensed network vision provider — Medically necessary screening, diagnosis, and treatment of eye and/or visual conditions — Three pairs of eyeglasses per calendar year with no review required by the health plan — Contact lenses deemed medically necessary when no other method can restore vision	Certain limits apply. Prior authorization may be required.

Abortion Policy

Medicaid Payment for abortions is restricted and the following criteria must be met: physician must certify in own handwriting on the basis of his professional judgment the life of pregnant woman would be endangered if the fetus was carried to term. Certification statement which contains the name and address of the recipient must be specified on the claim. Terminating a pregnancy due to rape of incest must meet the following requirements: The recipient will report the act of rape or incest to police unless the treating doctor certifies in writing the victim was too physically or psychologically incapacitated to report the rape or incest and must be submitted to the Bureau of Health Services Financing along with the treating physician's claim for reimbursement for performing an abortion. Recipient will certify that the pregnancy is the result of rape or incest, and this certification will be witnessed by the treating physician. The Office of Public Health Certification of Informed Consent-Abortion will be witnessed by treating physician and sent along with hard copy of claim.

Acadian Health Emergency Room Reduction Pilot Program

Effective 02/10/25, LDH announces an emergency room (ER) utilization reduction pilot program for 12 parishes comprising Region 4 (Lafayette area) and Region 5 (Lake Charles area). The program works by extending a PCP's practice into members' homes, offering treatment at home, and providing the ability to address nonmedical drivers of health. It provides mobile urgent treatment to patients, age 13 and older, for a wide array of non-life-threatening medical conditions with the intent of avoiding an unnecessary ER visit. The hours of operation are Monday through Sunday, 8 a.m.-10 p.m.

Acadian Health will be delivering a two-path program:

1. Acute Care at Home is an on-demand service for patients who require same day care within one hour. It serves as alternative care for non-traumatic hospitalizations for sick but stable patients who would otherwise seek care at the ER.

How it works:

- A member who is reporting an acute exacerbation of chronic disease is referred to Acadian Health by their provider, and an initial visit is scheduled.
- Once arriving on scene and conducting a comprehensive patient assessment, Acadian Health communicates with the PCP to report findings and request direction for care.
- Treatment is ordered, administered, and results and records are made available to the member's PCP through Acadian Health's electronic health record.

2. Clinic at Home is a proactive visit which is scheduled in advance, usually 24 hours ahead of time. This allows providers to extend their specialty practice into members' homes, offering after hours and weekend support and the ability to address non-medical drivers of health.

How it works:

- ABHLA will identify members who qualify for the program, obtain patient consent, and notify member's PCP. Members are enrolled via Acadian Health's online portal.
- The initial visit is completed, including all assessments and screenings, to identify needs, and a second visit is scheduled.
- Acadian Health connects with member's case manager to coordinate plan and community resources to address member needs and goals of care.
- Treatment is ordered, administered, and results and records are made available to the member's PCP through Acadian Health's electronic health record.

Acadian Health's services include assessment, treatment, and administration of medication. In addition to helping extend a provider's practice into a member's home, the physician collaborating care will be reimbursed for the applicable evaluation and management telehealth visit. For more information such as a full listing of services provided, parishes served, and reimbursable procedure codes visit https://ldh.la.gov/healthathome.

For more information: (337) 291-3333 or (800) 259-3333

For providers to schedule an Acute Care at Home visit for their patients: (337) 704-5829 or (844) 987-1395

Allergy Testing and Allergen Immunotherapy
ABHLA covers 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 allergy services shall include:

- In vitro specific IgE tests;
- Intracutaneous (intradermal) skin tests;
- Percutaneous skin tests;
- Ingestion challenge testing; and
- Allergen immunotherapy.

ABHLA covers allergy testing 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. ABHLA will cover allergen immunotherapy at:

A minimum of 180 doses every calendar year, per enrollee, for supervision of preparation and provision of antigens other than stinging or biting insects; and

A minimum of 52 doses every calendar year, per enrollee, for supervision of preparation and provision of antigens related to stinging or biting insects; allergen immunotherapy doses exceeding the above quantities when medically necessary shall be covered.

General Anesthesia/Facility Reimbursement Hospital Outpatient Dental
Additional reimbursement of $20.00 per time unit (each time unit is equal to 15 minutes). Providers must append modifier -23 to the anesthesia CPT code 00170 in addition to other appropriate anesthesia modifiers when a dental procedure is performed. The general anesthesia reimbursement formula has been revised to calculate the additional reimbursement. The additional reimbursement will be applied after all other calculations take place.

Facilities are reimbursed at least $400.00 per procedure. To receive the additional reimbursement, use CPT code 41899. To qualify for enhanced reimbursement, the procedure must take place in a hospital outpatient setting.

Anesthesia for Pain Management
ABHLA will cover epidurals that are administered for the prevention or control of acute pain, such as that which occurs during delivery or surgery, as professional services for this purpose only. Coverage for chronic intractable pain is dependent on the clinical etiology and the type of service or treatment.

If a member requests treatment for chronic intractable pain, depending on the underlying cause or anatomical defect, the provider may determine treatment or management to include physical therapy, occupational therapy, medication therapy management (MTM), epidural steroid injection (ESI) therapy, acupuncture, chiropractic, behavioral health, and substance use treatment services in coordination with case management. These include some alternative treatments, and the inclusion of coverage on the Professional Services Fee Schedule will define covered treatments.

Certain Medicaid procedures or services may require prior authorization. CPT codes for the treatment of chronic intractable pain requiring PA can be identified on the Professional Services Fee Schedule.

Breast Reconstructive Surgery
Breast Reconstruction surgery performed after a mastectomy is a covered service, but breast reconstruction to establish symmetry with contralateral breast is not covered.

Cardiovascular Services

ABHLA covers Invasive Coronary Angiography (ICA) and Percutaneous Coronary Intervention (PCI) for members aged 18 and over. This policy does not apply to members who are:

- Under the age of 18;

- Pregnant;
- Cardiac transplant members;
- Solid organ transplant candidates; and
- Survivors of sudden cardiac arrest.

Eligibility Criteria for Elective ICA

ABHLA covers elective ICA and considers it medically necessary in members with one or more of the following:

- Congenital heart disease that cannot be characterized by non-invasive modalities such as cardiac ultrasound, CT, or MRI;
- Heart failure with reduced ejection fraction for the purposes of diagnosing ischemic cardiomyopathy;
- Hypertrophic cardiomyopathy prior to septal ablation or myomectomy;
- Severe valvular disease or valvular disease with plans for surgery or percutaneous valve replacement;
- Type 1 myocardial infarction within the past three months defined by detection of a rise and/or fall of cardiac troponin values with at least one value above the 99th percentile upper reference limit and with at least one of the following:

    - Symptoms of acute myocardial ischemia;
    - New ischemic electrocardiogram (ECG) changes;
    - Development of pathological Q waves;
    - Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality in a pattern consistent with an ischemic etiology; and
    - Identification of a coronary thrombus;

- History of ventricular tachycardia requiring therapy for termination or sustained ventricular tachycardia not due to a transient reversible cause, within the past year;
- History of ventricular fibrillation;
- Return of angina within nine months of prior PCI;
- Members without chronic kidney disease who have Canadian Cardiovascular Society class I-IV classification of angina with intolerance of or failure to respond to at least two target dose anti-anginal medications (beta blocker, dihydropyridine or non-dihydropyridine calcium channel blocker, nitrates, and/or ranolazine); or
- High risk imaging findings, defined as one or more of the below:
    - Severe resting left ventricular dysfunction (LVEF ≤35%) not readily explained by noncoronary causes;
    - Resting perfusion abnormalities ≥10% of the myocardium in members without prior history or evidence of myocardial infarction;
    - Stress electrocardiogram findings including ≥2 mm of ST-segment depression at low workload or
    - persisting into recovery, exercise-induced ST-segment elevation, or exercise-induced ventricular tachycardia/ventricular fibrillation;
    - Severe stress-induced left ventricular dysfunction (peak exercise LVEF <45% or drop in LVEF with stress ≥10%);
    - Stress-induced perfusion abnormalities affecting ≥10% myocardium or stress segmental scores indicating multiple vascular territories with abnormalities;
    - Stress-induced left ventricular dilation;
    - Inducible wall motion abnormality (involving >2 segments or 2 coronary beds);
    - Wall motion abnormality developing at low dose of dobutamine (≥10 mg/kg/min) or at a low heart rate (<120 beats/min); or
    - Left main stenosis (≥50% stenosis) on coronary computed tomography angiography.

ICA for non-acute, stable coronary artery disease is not considered medically necessary, including for members with stable angina who are not interested in revascularization or who are not candidates for PCI or coronary artery bypass graft surgery.

Eligibility Criteria for Elective PCI

ABHLA covers elective PCI for angina with stable coronary artery disease and considers it medically necessary in members without chronic kidney disease who have Canadian Cardiovascular Society class I-IV classification of angina

with intolerance of or failure to respond to at least two target dose anti-anginal medications (beta blocker, dihydropyridine or non-dihydropyridine calcium channel blocker, nitrates, and/or ranolazine).

Elective PCI for other cardiac conditions is considered medically necessary in members with one or more of the following:

- Heart failure with reduced ejection fraction for the purposes of treating ischemic cardiomyopathy;
- Left main stenosis ≥50% as determined on prior cardiac catheterization or coronary computed tomography angiography, if the member has documentation indicating they were declined for a coronary artery bypass graft surgery; and
- Type 1 myocardial infarction within the past three months as defined by detection of a rise and/or fall of cardiac troponin values with at least one value above the 99th percentile upper reference limit and with at least one of the following:
  - Symptoms of acute myocardial ischemia;
  - New ischemic electrocardiogram changes;
  - Development of pathological Q waves;
  - Imaging evidence of new loss of viable myocardium, or new regional wall motion abnormality in a pattern consistent with an ischemic etiology; and
  - Identification of a coronary thrombus.

Elective PCI for non-acute, stable coronary artery disease is not considered medically necessary in all other member populations, including if the member is unwilling to adhere with recommended medical therapy, or if the member is unlikely to benefit from the proposed procedure (e.g., life expectancy less than six months due to a terminal illness).

Endovascular Revascularization for Peripheral Artery Disease

ABHLA covers endovascular revascularization procedures (stents, angioplasty, and atherectomy) for the lower extremity and consider them medically necessary for the following conditions:

- Acute limb ischemia;
- Chronic limb-threatening ischemia, defined as the presence of any of the following:
  - Ischemic pain at rest;
  - Gangrene; or
  - Lower limb ulceration greater than two weeks duration.

ABHLA also covers endovascular revascularization procedures and consider them medically necessary in members with peripheral artery disease who have symptoms of intermittent claudication and meet all of the following criteria:

- Significant peripheral artery disease of the lower extremity as indicated by at least one of the following:
  - Moderate to severe ischemic peripheral artery disease with ankle-brachial index (ABI) ≤0.69; or
  - Stenosis in the aortoiliac artery, femoropopliteal artery, or both arteries, with a severity of stenosis ≥70% by imaging studies; and
- Claudication symptoms that impair the ability to work or perform activities of daily living; and
- No improvement of symptoms despite all of the following treatments:
  - Documented participation in a medically supervised or directed exercise program for at least 12 weeks. Individuals fully unable to perform exercise therapy may qualify for revascularization only if the procedure is expected to provide long-term functional benefits despite the limitations that precluded exercise therapy; and
  - At least six months of optimal pharmacologic therapy including all of the below agents, unless contraindicated or discontinued due to adverse effects:
    - Antiplatelet therapy with aspirin, clopidogrel, or both
    - Statin therapy
    - Cilostazol
    - Antihypertensives to a goal systolic blood pressure ≤140 mmHg and diastolic blood pressure ≤90 mmHg; and

- At least one documented attempt at smoking cessation, if applicable, consisting of pharmacotherapy, unless contraindicated, and behavioral counseling, or referral to a smoking cessation program that offers both pharmacotherapy and counseling.

Exclusions

ABHLA does not consider endovascular revascularization procedures for the lower extremity not medically necessary in the following circumstances:

- Claudication due to isolated infrapopliteal artery disease (anterior tibial, posterior tibial or peroneal) including members with coronary artery disease, diabetes mellitus, or both;
- To prevent the progression of claudication to chronic limb-threatening ischemia in a member who does not otherwise meet medical necessity criteria;
- Member is asymptomatic; or
- Treatment of a nonviable limb.

Peripheral Arterial Disease Rehabilitation for Symptomatic Peripheral Arterial Disease

Peripheral arterial disease rehabilitation, also known as supervised exercise therapy, involves the use of intermittent exercise training for the purpose of reducing intermittent claudication symptoms.

ABHLA covers and considers 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. ABHLA will direct providers to adhere to CPT guidance on the time per session, exercise activities permitted, and the qualifications of the supervising provider.

Cochlear Implants

ABHLA covers unilateral or bilateral cochlear implants for members under 21 years of age when deemed medically necessary for treatment of severe-to-profound, bilateral sensorineural hearing loss. Implants must be used in accordance with Food and Drug Administration (FDA) guidelines.

Eligibility Criteria

A multidisciplinary implant team must collaborate to determine eligibility and to provide care. This team must include, at minimum, a fellowship-trained pediatric otolaryngologist or fellowship trained otologist, an audiologist, and a speech-language pathologist.

An audiological evaluation must find:

- Severe-to-profound hearing loss determined through the use of an age-appropriate combination of behavioral and physiological measures;
- Limited or no functional benefit achieved after a sufficient trial of hearing aid amplification;

A medical evaluation must include:

- Medical history;
- Physical examination verifying the candidate has intact tympanic membrane(s), is free of active ear disease, and has no contraindication for surgery under general anesthesia;
- Verification of receipt of all recommended immunizations;
- Verification of accessible cochlear anatomy that is suitable to implantation, as confirmed by imaging studies (computed tomography (CT) and/or magnetic resonance imagery (MRI)), when necessary; and
- Verification of auditory nerve integrity, as confirmed by electrical promontory stimulation, when necessary.

For bilateral cochlear implants, an audiologic and medical evaluation must determine that a unilateral cochlear implant plus hearing aid in the contralateral ear will not result in binaural benefit for the member.

Non-audiological evaluations must include:

- Speech and language evaluation to determine the member's level of communicative ability; and

- Psychological and/or social work evaluation, as needed.

Pre-operative counseling must be provided to the member, if age appropriate, and the member's caregiver and must provide:

- Information about implant components and function; risks, limitations, and potential benefits of implantation; the surgical procedure; and postoperative follow-up schedule;
- Appropriate post-implant expectations, including being prepared and willing to participate in pre- and post-implant assessment and rehabilitation programs; and
- Information about alternative communication methods to cochlear implants.

Preoperative Evaluation

When prior authorized, ABHLA will reimburse preoperative evaluation services (i.e., evaluation of speech, language, voice, communication, auditory processing, and/or audiologic/aural rehabilitation) even when the member may not subsequently receive an implant.

Implants, Equipment, Repairs, and Replacements

ABHLA will make reimbursement to the hospital at the time of surgery for both the implant and the per diem. The implant and the implantation surgery must be prior authorized by submitting the PA-01 form. After approval has been granted, the hospital must bill for the implant(s) by submitting the appropriate HCPCS code on a CMS 1500 claim form. Write the letters DME in bold, black print on the top of the form and the PA number written in item 23.

ABHLA will cover:

- All costs for upgrades and repairs to the component parts of the implant; and
- All costs for cords and batteries:

Implantation Procedure, Postoperative Rehabilitative Costs, and Subsequent Therapy

ABHLA covers the cochlear implant surgery as well as postoperative aural rehabilitation by an audiologist and subsequent speech, language, and hearing therapy.

Post-Operative Programming

ABHLA covers cochlear implant post-operative programming and diagnostic analysis services.

Non-Covered Expenses

The following items are non-covered expenses:

- Service contracts and/or extended warranties; and
- Insurance to protect against loss and theft.

Corneal Collagen Cross-Linking (CXL)

CXL is a procedure used to treat progressive keratoconus. Keratoconus is a progressive ocular disease that increases the curvature of the cornea, leading to decreased visual acuity. Ultraviolet (UV) light is combined with riboflavin eye drops to induce collagen crosslinks in the cornea, strengthening and stabilizing the cornea and delaying progressive deformation. The CXL procedure, including the riboflavin drops and administration of UV light, is approved for patients between 14-20 years of age with progressive keratoconus.

Coverage guidelines for CXL are made in accordance with the Louisiana Medicaid program definition of medical necessity. The guidelines are as follows:

- Epithelium-off photochemical CXL using riboflavin and ultraviolet A may be considered medically necessary for treatment of progressive keratoconus **when conservative treatments (e.g., spectacles and contact lens) have been tried without success and the individual does not have either of the following contraindications: a corneal thickness of fewer than 400 microns or a prior herpetic ocular infection.**
- Progressive keratoconus is defined as one or more of the following:
    - An increase of 1 diopter (D) in the steepest keratometry value; or

- An increase of 1 D in regular astigmatism evaluated by subjective manifest refraction; or
- A myopic shift (decrease in the spherical equivalent) of 0.50 D on subjective manifest refraction; or
- A decrease > 0.1 mm in the back optical zone radius in rigid contact lens wearers where other information was not available.

CXL can be billed using the following codes:

- 0402T: collagen cross-linking of cornea (including removal of the corneal epithelium and measurement of corneal thickness).
- J2787: riboflavin 5'-phosphate, ophthalmic solution, up to 3 mL.

Continuous Glucose Monitoring Devices

Effective with dates of service on or after August 1, 2022, Louisiana Medicaid will change the criteria for long-term continuous glucose monitoring (CGM) devices through the durable medical equipment program. Prior authorization is required, and beneficiaries must meet one of the 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.

CGM devices require a prescription and documentation of medical necessity. In addition, beneficiaries who receive this coverage are required to attend regular follow-up visits with a healthcare provider at a minimum of every six months to assess the on-going benefits. CGM sensor coverage will not change. The lifespan of a CGM sensor varies. The sensor may last 7, 10, or 14 days. The rate on file for CGM sensors incorporates these varying lifespans and represents a monthly rate rather than per unit rate. Louisiana Medicaid will not consider short-term CGMs as a covered device.

Continuous Positive Airway Pressure (CPAP)

Prior authorization is required. To be eligible to receive a CPAP machine, members must meet the following criteria:

- Have a diagnosis of obstructive sleep apnea (OSA);
- Have a Polysomnogram (PSG) sleep test performed in a facility-based sleep study laboratory;
- Meet medical necessity criteria for requested device.

For adults, a single level CPAP device is covered if the member has a diagnosis of OSA that has been documented by an attended facility-based polysomnogram and meets either of the following criteria:

- The AHI is greater than or equal to 15 events per hour; or
- The AHI is from 5 to 14 events per hour with documented symptoms of:
  - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia;
  - Hypertension, ischemic heart disease, or history of stroke.

For members under the age of 21, a single level CPAP device is covered if the member has a diagnosis of OSA that is documented by an attended, facility-based polysomnogram and has the following:

- Documentation of physical exam (including airway) and of any other medical condition, which may be correctable (e.g., tonsillectomy and/or adenoidectomy) prior to the institution of assisted ventilation;
- Documentation of how sleep disturbance reduces the quality of life and affects the activities of daily living;
- Prescription by a physician with training and expertise in pediatric respiratory sleep disorders;
- Documentation of the medical diagnosis, which is known to cause respiratory/sleep disorders;
- Sleep or respiratory study documenting two or more of the following:
  - Oxygen saturation of less than 90 percent pulse oximetry or partial pressure of transcutaneous or arterial of less than 60mm. Hg.;
  - Carbon dioxide greater than 55 mm. Hg. Bye end tidal, transcutaneous, arterial, or capillary blood measurement; and
  - Apnea of 10 to 20 seconds duration on the average of one per hour.
- A follow up plan should be submitted identifying the responsible physician or facility, giving data collected to demonstrate the success or failure of intervention, and showing a visit within the first month of use and a second assessment within the first three months of use;
- Indication of a responsible, committed home environment and of caregivers properly trained in appropriate

respiratory care; and
- A written plan for home health follow-up care.

Contraceptive Implants and Intrauterine Contraceptive Systems
ABHLA covers the insertion and removal of all FDA-approved contraceptive implants and intrauterine contraceptive systems.

CPT Vest-High Frequency Chest Wall Oscillation Device
CPT Vest-High Frequency Chest Wall Oscillation devices are covered when medically necessary and require prior authorization. To be eligible, a member must:
- Have a diagnosis of Cystic Fibrosis or Bronchiectasis
  - Must be characterized by daily productive cough for at least six (6) continuous months or frequent (i.e. more than two years) exacerbations requiring antibiotic therapy; and
  - Confirmed by high resolution, spiral, or standard CT scan
- Have a neuromuscular disorder OR well documented failure of standard treatments to adequately mobilize retained secretions with all of the following:
  - Chest Physical Therapy and flutter device at least twice daily (when age appropriate)
  - Pattern of hospitalizations at least annually or more
  - Significantly deteriorating clinical condition
  - Be under the care of a pulmonologist
  - Have copies of two pulmonary test results that indicate the member's condition improved with the use of the vest
- Meet medical necessity criteria for the requested device

Dental Care for Adults with Developmental or Intellectual Disabilities Residing in an Intermediate Care Facility
Effective 05/01/2023, in accordance with Act 366, adults 21 years of age and older with developmental or intellectual disabilities who reside in an intermediate care facility (ICF) will receive coverage for comprehensive dental care. Some diagnostic services, such as exams and some radiographic images, will be provided by the ICF. These services include D0120, D0150, D0210, D0240, D0272 and D0330. Providers should bill these services to the ICF. The following services should be billed to the beneficiary's assigned Dental Benefit Plan Manager (DBPM):
- Diagnostic services (excluding the codes listed above)
- Preventive services
- Restorative services
- Endodontics
- Periodontics
- Prosthodontics
- Oral and maxillofacial surgery
- Orthodontics
- Emergency care

Emergency Oxygen Equipment and Supplies
Medically necessary backup oxygen and equipment provided during an official state and/or federally declared emergency is covered. Backup oxygen and equipment provided outside an official state and/or federally declared emergency is non-covered. Providers are responsible for ensuring that medical oxygen and oxygen-related equipment are available during official state and/or federally declared emergencies, if medically necessary. Providers will not be reimbursed for unused equipment and supplies picked up after an emergency.

Freestanding Birthing Centers
Medicaid will cover delivery services for Medicaid recipients at free standing birthing centers. Centers will be reimbursed a one-time payment for each delivery equal to 90% of average per diem rates of surrounding hospitals providing labor and delivery services. Birthing centers are allowed to bill and be reimbursed for the code vaginal delivery only with a modifier 53. Reimbursement will be 75% of the professional services published fee schedule rate

for services within the licensed midwife's scope of practice. Professional providers may bill and be reimbursed for each delivery by submitting the code for vaginal delivery only on their professional claims.

Genetic Testing and Counseling

In alignment with LDH policy, ABHLA requires that genetic counseling be provided to members both before and after all genetic testing. Genetic counseling must be documented in the member's medical record and, at a minimum, must include the following elements:

- Obtaining a structured family genetic history;
- Genetic risk assessment; and
- Counseling of the beneficiary and family about diagnosis, prognosis, and treatment.

When performed by licensed genetic counselors, services are reimbursed 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, an applicable evaluation and management (E&M) code must be used.

<u>BRCA1 and BRCA2 Testing</u>

In alignment with the Louisiana Medicaid Professional Services Manual, genetic testing for BRCA1 and BRCA2 mutations in cancer-affected and cancer-unaffected individuals is considered medically necessary when the beneficiary:

- Has any blood relative with a known BRCA1/BRCA2 mutation
- Meets the criterial below but with previous, limited testing (e.g., single gene and/or absent deletion duplication analysis) interested in pursuing multi-gene testing
- Has a personal history of cancer, defined as one of more of the following:
  - Breast cancer and one or more of the following:
    - Diagnosed at age 45 or younger, or
    - Diagnosed at age 45—50 with:
      - Unknown or limited family history; or
      - A second breast cancer diagnosed at any age; or
      - At least one close blood relative with breast, ovarian, pancreatic, or high-grade (Gleason score of at least 7) or intraductal prostate cancer at any age
    - Diagnosed with triple negative breast cancer at age 60 or younger;
    - Diagnosed at any age with:
      - Ashkenazi Jewish ancestry; or
      - At least one close blood relative with breast cancer at under 50 years of age or ovarian, pancreatic, or metastatic or intraductal prostate cancer at any age; or
      - At least three total diagnoses of breast cancer in patient and/or close blood relatives
    - Diagnosed at any age with male breast cancer; or
    - Epithelial ovarian cancer (including fallopian tube cancer or peritoneal cancer) at any age;
  - Exocrine pancreatic cancer at any age;
  - Metastatic or intraductal prostate cancer at any age;
  - High-grade (Gleason score at least 7) prostate cancer at any age with:
    - Ashkenazi Jewish ancestry; or
    - At least one close blood relative with breast cancer diagnosed at age 50 or younger, or ovarian, pancreatic, or metastatic or intraductal prostate cancer at any age; or
    - At least two close blood relatives with breast or prostate cancer (any grade) at any age
  - A mutation identified on tumor genomic testing that has clinical implications if also identified in the germline
  - To aid in systemic therapy decision-making, such as for HER2-negative metastatic breast cancer
- Has a family history of cancer, including unaffected individuals defined one or more of the following:
  - An affected or unaffected individual with a 1st- or 2nd-degree blood relative meeting any of the criterion listed above (except individuals who meet criteria only for systemic therapy decision-making); or

- An affected or unaffected individual who otherwise does not met criteria above but also has a probability >5% of a BRCA1/2 pathogenic variant based on prior probability models (e.g., Tyer-Cuzick, BRCAPro, Pennll)

Genetic testing in individuals not meeting the above criteria is considered not medically necessary and are not covered.

The following CPT Codes for BRCA1 and BRCA2 genetic testing are covered where medically necessary: 81162 – 81167, 81212, 81215 - 81217

Claims for the above genetic testing services for Members under 19 years of age are not covered and may be denied.

Hospice

To be eligible for hospice care, a member must meet all Louisiana Medicaid eligibility criteria and be certified as "terminally ill", defined as a medical prognosis of limited expected survival, of approximately six months or less at the time of the referral to hospice, of a member who is experiencing an illness for which therapeutic strategies directed toward cure and control of the disease alone are no longer appropriate.

Members under 21 who are approved for hospice may continue to receive life-prolonging treatments focused on treating, modifying, or curing a medical condition so that the beneficiary may live as long as possible, even if that condition is also the hospice qualifying diagnosis. The hospice agency is responsible for either providing or paying for all hospice services. The hospice provider is not responsible for reimbursement for life-prolonging therapies. Reimbursement for concurrent care shall be to the providers furnishing the care and made separately from the hospice per diem.

The following core services must be available twenty-four (24) hours per day: physician services, nursing services, medical social service, counseling services, dietary counseling, bereavement counseling, pastoral care, short-term inpatient care, inpatient respite care, hospice aide and homemaker services, and therapy services.

For the duration of election, members 21 years or older waive all rights to the following covered services:

- Hospice care provided by a hospice agency other than the hospice agency designated by the beneficiary or a person authorized by law to consent to medical treatment for the beneficiary; and
- If the beneficiary is 21 years or older, any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected services for a related condition, or services that are equivalent to hospice care, except for services provided by:
  - The designated hospice provider;
  - Another hospice provider under arrangements made by the designated hospice provider; and
  - The beneficiary's attending physician if that physician is not an employee of the designated hospice provider or receiving compensation from the hospice provider for those services.
- Beneficiaries who elect hospice services may also receive early and periodic screening, diagnosis, and treatment (EPSDT), pediatric day health care (PDHC), personal care services (PCS), and intermittent or extended home health services concurrently.

Please visit the **UM Criteria** page of the ABHLA provider website for additional patient and reimbursement criteria

Human Donor Milk Outpatient

ABHLA will cover human donor milk as an outpatient service for use by medically vulnerable infants.

Eligibility Criteria:
Donor human milk is considered medically necessary when the following criteria are met:

- The beneficiary is less than 12 months of age with one or more of the following conditions:
  - Post-surgical nutrition;
  - Organ transplantation;
  - Renal disease;
  - Short gut syndrome;
  - Malabsorption syndrome;
  - Feeding or formula intolerance;

  - Failure to thrive;
  - Inborn errors of metabolism;
  - Immunologic disorders;
  - Congenital heart disease or other congenital anomalies; or
  - Neonatal abstinence syndrome.
- The beneficiary'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; or the beneficiary is medically or physically unable to receive caregiver breast milk or participate in breastfeeding; and
- The beneficiary's caregiver has received education on donor human milk, including the risks and benefits; and
- A bank accredited by, and in good standing with, the Human Milk Banking Association of North America supplied the donor human milk.

Reimbursement:
Prescriptions for donor human milk must include the following:
- Number of prescribed calories per ounce;
- Total ounces prescribed per day;
- Total number of weeks donor human milk is required;
- Total allowable refills; and
- Reason for prescribing donor human milk, including beneficiary's diagnoses.

Prior authorization is not required for donor human milk. Donor human milk is, however, subject to post payment medical review. The DME provider must submit a prescription containing all required documentation along with a hard copy claim to the department's fiscal intermediary. Failure to provide required documentation, or if the documentation submitted fails to establish medical necessity, will result in recoupment of the payment for the donor human milk.

In Lieu of Services
In lieu services are additional benefits offered by the health plan that are outside the scope of core benefits and services to individual members on a case-by-case basis, based on medical necessity, cost-effectiveness, the wishes of the member and or member's family, the potential for improved health status of the member, functional necessity and what is deemed appropriate by the medical director. Those services must represent medically appropriate treatments and not be indicated as "investigational" as determined by the medical director. In that instance, the medically appropriate non-covered service may be reviewed to determine if it is also cost-effective, and if deemed so, may be approved despite the non-covered status.

Physical Health In Lieu of services

In Lieu of Services	Alternative Medicaid State Plan Service (s)
Chiropractic Services for adult age 21 and older with disorders of the spine provide medically appropriate treatment of neuromuscular disorders. No authorization is required for up to 18 treatment sessions per year. Additional sessions may require authorization.	Inpatient and Outpatient Hospitals, Physician services, nurse practitioner services, other licensed practitioner's services, laboratory and x-ray services, and prescribed drugs.
Doula Services are provided by a non-licensed person trained in supporting healthy pregnancies in a home setting under the supervision of a Doula Agency affiliated with a physician practice. Doulas assist the member to create birth plan.	Inpatient Hospitals visits, outpatient hospitals visits, home visits, postpartum visits, and assistance with breast feeding, supervised by physician services, nurse practitioner services, other licensed practitioners' services

"Incident To" Services

"Incident to" services means 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 (e.g., 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.

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, 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.

Maternal Fetal Medicine
Prenatal Visits: ABHLA will cover two initial prenatal visits per pregnancy (270 days). These two visits may not be performed by the same attending provider.
A member will be considered a 'new patient' for each pregnancy whether or not the member is a new or established patient to the provider/practice. The appropriate level E&M CPT procedure code be billed for the initial prenatal visit with the TH modifier is required. A pregnancy-related diagnosis code must also be used on the claim form as either the primary or secondary diagnosis.

Reimbursement for the initial prenatal visit, which must be modified with TH, will include, but is not limited to, the following:
- Estimation of gestational age by ultrasound or firm last menstrual period. (If the ultrasound is performed during the initial visit, it may be billed separately. Also, see the ultrasound policy);
- Identification of patient at risk for complications including those with prior preterm birth;
- Health and nutrition counseling; and
- Routine dipstick urinalysis.

If the pregnancy is not verified, or if the pregnancy test is negative, the service may only be submitted with the appropriate level E&M without the TH modifier. ABHLA will require notification by the provider of obstetrical care at the time of the first visit of the pregnancy.

*Fetal Non-Stress Test: F*etal non-stress tests are covered when medically necessary as determined by meeting one of the following criteria:
- The pregnancy is post-date/post-maturity (after 41 weeks gestation);
- The treating provider suspects potential fetal problems in an otherwise normal pregnancy; or
- The pregnancy is high risk, including but not limited to diabetes mellitus, pre-eclampsia, eclampsia, multiple gestations, and previous intrauterine fetal death.

*Fetal Biophysical Profile: F*etal biophysical profiles are covered when medically necessary, as determined by meeting at least two of the following criteria:
- Gestation period is at least 28 weeks
- Pregnancy must be high-risk, and if so, the diagnosis should reflect high risk
- Uteroplacental insufficiency must be suspected in a normal pregnancy

Pediatric Day Healthcare Services

The Medicaid Pediatric Day Health Care (PDHC) program is designed to provide an array of services to meet the medical, social and developmental needs of children from birth up to twenty-one (21) years of age, who have a complex medical condition which requires skilled nursing care and therapeutic interventions, on an ongoing basis to preserve and maintain health status, prevent death, treat/cure disease, ameliorate disabilities or other adverse health conditions and/or prolong life. PDHC is to serve as a community-based alternative to long-term care and extended in-home nursing care. PDHC does not provide respite care, and it is not intended to be an auxiliary (back-up) for respite care. All PDHC services must be prior authorized. Services may be provided seven days a week and up to twelve (12) hours per day for qualified Medicaid recipients as documented in the plan of care (POC).

PDHC services require prior authorization from the health plan. The PDHC prior authorization (PA) form is standardized regardless of the health plan covering the services. To receive prior authorization from the FI or the health plan, the following documentation must be sent for each request:

- Standardized prior authorization form which must include why the services provided at the PDHC cannot be provided elsewhere, including the school system;
- Physician's most recent note documenting medical necessity for the PDHC;
- The physician's order and POC for PDHC;
- The Prior Authorization checklist indicating the recipient's skilled nursing care requirements;
- A signed parental/guardian consent form

The PDHC facility Medicaid per diem rate includes the following services/equipment:

- Nursing Care
- Respiratory Care
- Physical Therapy
- Speech-Language Therapy
- Occupational Therapy
- Social Services
- Personal care services (activities of daily living) and
- Transportation to and from the PDHC facility. Transportation will be paid in a separate per diem.

In order to qualify for PDHC services, a recipient must meet all of the following criteria. The recipient must:

- Be Louisiana Medicaid eligible
- Be from birth up to twenty-one (21) years of age
- Have a medically complex condition which involves one or more physiological or organ systems and requires skilled nursing care and therapeutic interventions performed by a knowledgeable or experienced licensed professional registered nurse (RN) or licensed practical nurse (LPN) on an ongoing basis to preserve and maintain health status, prevent death, treat/cure disease, ameliorate disabilities or other adverse health conditions, and/or prolong life.
- Be a candidate for outpatient medical services in a home or community-based setting; and
- Have a signed physician's order and POC for PDHC by the recipient's physician specifying the frequency and duration of services. The POC must clearly outline the skilled nursing care and therapeutic interventions that will be performed in the PDHC.
- The POC must be individualized, specific and consistent with the symptoms or confirmed diagnosis of the disease, condition, or injury under treatment, and not in excess of the recipient's needs.

The initial POC should consist of the following components:

- Provider Information - Name and Medicaid provider number
- Start of care date and certification period
- Recipient's functional limitations, rehabilitation potential, mental status, level of activity status, precautions, method of transportation to and from facility and allergies
- Other special orders/instructions
- Medications, treatments, and any required equipment
- Monitoring criteria, monitoring equipment and supplies
- Nursing services to be provided

- Diet as indicated and how recipient is to be fed
- Recipient's current medical condition and hospitalizations within last six months;
- Risk factors associated with medical diagnoses
- Special goals for care identified: Plans for achieving the goals will be determined and an evaluation schedule of progress will be established
- Frequency/Duration of PDHC services – number of days/week, hours/day and anticipated duration

All services the recipient is receiving, including waiver and other community supports and services must be considered and reflected and

- Discharge plans – contain specific criteria for transitioning from or discontinuing participation in the PDHC with the facility.
- Signatures by the prescribing physician, an authorized representative of the facility and the recipient's parent or guardian and mut be legible and dated.

The POC for continuation of services will include the above components. In addition, the revised POC will include accomplishments toward goals, assessment of the effectiveness of services and acknowledgment of face-to-face evaluation between the recipient and prescribing physician every ninety (90) days. The physician will certify on the prior authorization form that they have read the progress report from the previous period, and the renewal must be incorporated into the recipient's clinical record within seven calendar days of receipt of the prescribing physician's order.

In the event, the medical director of the PDHC facility is also the recipient's prescribing physician, LDH, fiscal intermediary (FI) or managed care organization (MCO) will review the order and POC for the recommendation of the recipient's participation in the PDHC Program.

The PDHC facility will provide or arrange for the transportation of the member to and from the facility because of the complex special needs of the child. The family may choose to provide their own transportation. Transportation to and from the PDHC facility is reimbursed at a daily per diem rate in accordance with 42 CFR 440.170(a).

Neither the Medicaid Program nor the contracted MCO will reimburse a PDHC for DME and supplies that are provided to the recipient through the Medicaid DME program.

The parent or guardian is to supply medications each day as prescribed by the recipient's attending physician or by a specialty physician after consultation and coordination with the PDHC facility. PDHC staff will administer medications, as ordered or prescribed, while the recipient is on site.

The procedure codes indicate if the member is authorized for a half day or full day and includes transportation code.

- T1025 – Full day of PDHC Services over six (6) hours up to twelve (12) hours per day
- T1026 – Hourly PDHC services six (6) hours or less per day
- T2002 – Transportation services per diem

This is to be used on days when the child cannot attend for the full day so that providers can bill for the actual service hours of six (6) hours or less. These two procedure codes cannot be billed for the same day. For reimbursement purposes, PDHC services begin when the PDHC staff assumes responsibility for the care of the child and ends when care is relinquished to the parent or guardian.

Rapid Whole Genome Sequencing of Critically Ill Infants

ABHLA will cover rapid whole genome sequencing performed in the inpatient setting for infants with complex illness of unknown etiology. Rapid whole genome sequencing includes: individual sequencing, trio sequencing of the parents of the infant, and ultra-rapid sequencing.

Rapid whole genome sequencing is considered medically necessary for infants less than 12 months of age who are receiving inpatient hospital services in an intensive care or pediatric unit if they meet the following criteria:

- Are suspected of having a rare genetic condition that is not diagnosable by standard methods;

- Have symptoms that suggest a broad differential diagnosis that requires an evaluation by multiple genetic tests if advanced molecular techniques, including, but not limited to, traditional whole genome sequencing, rapid whole genome sequencing, and other genetic and genomic screening, are not performed;
- Timely identification of a molecular diagnosis is necessary to guide clinical decision making, and the advanced molecular techniques including, but not limited to, traditional whole genome sequencing, rapid whole genome sequencing, and other genetic and genomic screening results may guide the treatment or management of the infant's condition;
- Have an illness with at least one of the following features:
    - Multiple congenital anomalies;
    - Specific malformations highly suggestive of a genetic etiology;
    - Abnormal laboratory tests suggesting the presence of a genetic disease or complex metabolic phenotype like, but not limited to, an abnormal newborn screen, hyperammonemia, or lactic acidosis not due to poor perfusion;
    - Refractory or severe hypoglycemia;
    - Abnormal response to therapy related to an underlying medical condition affecting vital organs or bodily systems;
    - Severe hypotonia;
    - Refractory seizures;
    - A high-risk stratification on evaluation for a brief resolved unexplained event with any of the following:
        - A recurrent event without respiratory infection,
        - A recurrent witnessed seizure-like event, or
        - A recurrent cardiopulmonary resuscitation;
    - Abnormal chemistry levels including, but not limited to, electrolytes, bicarbonate, lactic acid, venous blood gas, and glucose suggestive of inborn error of metabolism;
    - Abnormal cardiac diagnostic testing results suggestive of possible channelopathies, arrhythmias, cardiomyopathies, myocarditis, or structural heart disease; or
    - Family genetic history related to the infant's condition.

Rapid whole genome sequencing requires prior authorization and must be ordered by the infant's treating physician. The ordering physician must be a medical geneticist or other physician sub-specialist including, but not limited to, a neonatologist or pediatric intensivist with expertise in the conditions and/or genetic disorder for which testing is being considered. Counseling is required before and after all genetic testing, and must be documented in the medical record, as per the Genetic Counseling and Testing section of the Louisiana Medicaid Provider Manual.

ABHLA will reimburse rapid whole genome testing separately from the hospital reimbursement for inpatient services. The minimum reimbursement for rapid whole genome sequencing (including reimbursement for individual sequencing, trio sequencing of the parents of the infant, and ultra-rapid sequencing) is equal to the fees on the Louisiana Medicaid Laboratory and Radiology (Non-Hospital) Fee Schedule in addition to the minimum per diem as published in the Louisiana Medicaid Inpatient Hospital Per Diem Fee Schedule. Hospitals must bill the rapid whole genome sequencing claim using the appropriate CPT code on a CMS 1500 claim form. If the hospital bills electronically, the 837P must be used.

Respiratory Viral Panels

CPT code 87631 is deemed medically necessary in the following instances and may be performed by a PCP if needed:

- Infants receiving monthly RSV prophylaxis with palivizumab because of high-risk conditions such as prematurity, respiratory disease, or cardiac disease.
- Long-term care facility residents returning to a facility, or a person of any age returning to a congregate setting.

CPT codes 87632 and 87633 are deemed potentially medically necessary only for:

- Beneficiaries with serious or critical illness or at imminent risk of becoming seriously or critically ill, immunodeficiency, and/or severe underlying condition contributory to testing using an expanded syndromic panel.

Testing is approved for the following places of service (POS):

- Places of service (POS) 19 – off-campus outpatient hospital, 21 – inpatient hospital, 22 – on-campus outpatient hospital, 23 – emergency room.

PLEASE NOTE: Tests should be ordered as follows (for healthcare POS other than those listed in the above bullet): Testing for these services should only occur in accordance with one or more of the following instances:

  - For immune-competent beneficiaries, the test must be ordered by an infectious disease specialist or pulmonologist who is diagnosing and treating the beneficiary.
  - For immune-compromised beneficiaries, the test must be ordered by a clinician specialist in one of the following: infectious diseases, oncology, transplant (for any panel), or pulmonologist who is diagnosing and treating the beneficiary.

PLEASE NOTE: Regarding the previous two bullets, an exception may be made within geographic locations where the specialist(s) cannot be reasonably reached by the beneficiary; AND the beneficiary is under the care of one of these providers: infectious diseases, oncology, transplant (for any panel), or pulmonologist; AND the ordering provider is located closer to the beneficiary's place of residence than the nearest specialist. This exception is intended for beneficiaries living in rural locations with limited clinical specialist access only.

Screening Mammography

ABHLA will cover one screening mammogram (film or digital) per calendar year for beneficiaries meeting one or more of the following criteria:

- Any woman aged 30 or older with hereditary susceptibility from pathogenic mutation carrier status or prior chest wall radiation.
- Provider recommendation for any woman 35 years of age or older with a predicted lifetime risk greater than 20 percent.
- Any woman who is 35 through 39 years of age. Please note: Only one baseline mammogram is allowable between this age range for beneficiaries not meeting other criteria.
- Any woman who is 40 years of age or older.

Sinus Procedures

Balloon ostial dilation and functional endoscopic sinus surgery are considered medically necessary for the treatment of chronic rhinosinusitis when all of the following criteria are met:

- Uncomplicated chronic rhinosinusitis limited to the paranasal sinuses without the involvement of adjacent neurological, soft tissue, or bony structures that has persisted for at least 12 weeks with at least two of the following sinonasal symptoms:
  - Facial pain/pressure;
  - Hyposmia/anosmia;
  - Nasal obstruction;
  - Mucopurulent nasal discharge; and
- Sinonasal symptoms that are persistent after maximal medical therapy has been attempted, as defined by all of the following, either sequentially or overlapping:
  - Saline nasal irrigation for at least six weeks;
  - Nasal corticosteroids for at least six weeks;
  - Approved biologics, if applicable, for at least six weeks;
  - A complete course of antibiotic therapy when an acute bacterial infection is suspected;
  - Treatment of concomitant allergic rhinitis, if present; and
- Objective evidence of sinonasal inflammation as determined by one of the following:
  - Nasal endoscopy; or
  - Computed tomography.

Balloon ostial dilation and functional endoscopic sinus surgery are not covered and not considered medically necessary in the following situations:

- Presence of sinonasal symptoms but no objective evidence of sinonasal disease by nasal endoscopy or computed tomography;
- For the treatment of obstructive sleep apnea and/or snoring when the above criteria are not met;
- For the treatment of headaches when the above criteria are not met; and
- For balloon ostial dilation only, when sinonasal polyps are present.

Skin Substitutes

Skin substitutes are covered for the treatment of partial- and full-thickness diabetic lower extremity ulcers when the member meets all of the following requirements:

- A lower extremity ulcer is present and:
  - Is at least 1.0 square centimeter (cm) in size;
  - Has persisted for at least 4 weeks;
  - Has not demonstrated measurable signs of healing, defined as a decrease in surface area and depth or a decreased amount of exudate and necrotic tissue, with comprehensive therapy including all of the following:
    - Application of dressings to maintain a moist wound environment;
    - Debridement of necrotic tissue, if present; and
    - Offloading of weight.
  - A diagnosis of type 1 or type 2 diabetes mellitus;
  - A glycated hemoglobin (HbA1c) level of ≤ 9% within the last 90 days or a documented plan to improve HbA1c to 9% or below as soon as possible;
  - Evidence of adequate circulation to the affected extremity, as indicated by one or more of the following:
    - Ankle-brachial index (ABI) of at least 0.7;
    - Toe-brachial index (TBI) of at least 0.5;
    - Dorsum transcutaneous oxygen test (TcPO2) >= 30 mm Hg; and
  - Triphasic or biphasic Doppler arterial waveforms at the ankle of the affected leg.
  - No evidence of untreated wound infection or underlying bone infection; and
  - Ulcer does not extend to tendon, muscle, joint capsule, or bone or exhibit exposed sinus tracts unless the product indication for use allows application to such ulcers.

The beneficiary must not have any of the following:

- Active Charcot deformity or major structural abnormalities of the foot, when the ulcer is on the foot;
- Active and untreated autoimmune connective tissue disease;
- Known or suspected malignancy of the ulcer;
- Beneficiary is receiving radiation therapy or chemotherapy; and
- Re-treatment of the same ulcer within one year.

Coverage Limitations

The following coverage limitations apply:

- Coverage is limited to a maximum of 10 treatments within a 12-week period;
- If there is no measurable decrease in surface area or depth after five applications, then further applications are not covered;
- For all ulcers, a comprehensive treatment plan must be documented, including at least all of the following:
  - Offloading of weight;
  - Smoking cessation counseling and/or medications, if applicable;
  - Edema control;
  - Improvement in diabetes control and nutritional status; and
  - Identification and treatment of other comorbidities that may affect wound healing such as ongoing monitoring for infection.
- While providers may change products used for the diabetic lower extremity ulcers, simultaneous use of more than one product for the diabetic lower extremity ulcers is not covered; and
- Hyperbaric oxygen therapy is not covered when used at the same time as skin substitute treatment.

Prior Authorization

Skin substitutes require prior authorization, and submitted medical documentation must demonstrate that the beneficiary meets all of the aforementioned requirements.

NOTE: If there is no measurable decrease in surface area, or depth after five applications, then further applications are not covered, even when prior authorized.

Urine Drug Screening

Aetna Better Health of LA will employ a claim edit to eliminate coverage of CPT codes 80320-80377 to test for individual substance(s) or metabolites and will employ a claim edit eliminating coverage of G0482 and G0483.

- Presumptive drug testing is limited to twenty-four (24) total tests per enrollee per calendar year, with no more than two (2) in one (1) month.
- Definitive drug testing is limited to twelve (12) total tests per enrollee per calendar year, with no more than one (1) per month. Testing more than fourteen (14) definitive drug classes per day is not reimbursable.

NOTE: No more than one presumptive drug test AND one definitive test are reimbursed per day per enrollee, from the same or different provider.

Codes/Condition of Coverage

Definitive tests should not routinely be the first tests of choice. Rather, presumptive testing should be a routine part of initial and on-going assessment.

Definitive testing is medically indicated when:

- The presumptive test was negative for prescribed medications AND the enrollee disputes the results
- The presumptive test was positive for a prescription drug with SUD potential that was not prescribed AND the enrollee disputes the results
- The presumptive test was positive for an illegal drug AND the enrollee disputes the results.

Routine use of definitive testing following expected negative presumptive testing is not medically necessary.

Definitive tests may be ordered when definitive testing for substances with potential of SUD is required based on the enrollee-specific history and treatment plan and the indications above.

American Society of Addiction Medicine (ASAM) has defined a total of 9 classes of substances with potential of SUD:

- Amphetamines
- Opiates
- Phencyclidine
- Barbiturates
- Propoxyphene
- Benzodiazepines
- Marijuana
- Cocaine
- Methadone

When choosing between G0480 and G0481, consider which drug classes are pertinent to the care of each enrollee based on the medical indications listed above; the target drug classes should be documented on the order for the test and in the medical record.

Wearable Cardioverter Defibrillator

Procedure code K0606 Health Plans were denying the Wearable Cardioverter Defibrillator. This device is a covered DMEPOS service for rental only and is located on the DMEPOS Fee Schedule/ Prior Authorization is required for this service to verify the medical necessity of the WCD and the WCD will not be used for experimental or investigational purposes. Device is for patients 18 years or older.

Additional Services

Adult Dental Benefits

We will offer an exam and cleaning twice a year as well as a bitewing X-rays annually to adult members, every year we will cover up to $1000 care including fillings and extractions. Only available to adult members aged 21 and over who do not have dental coverage through another source. Covered services include the following:

- Preventative and diagnostic services once every six (6) months
- Restorative and Oral & Maxillofacial Surgery based on tooth and surface
    - Members can receive restorative services multiple times per year, but fillings for the same tooth and service are covered one every 36 months (tooth dependent)
    - Extractions can be performed multiple times per year over the course of multiple visits

Aetna Better Health of Louisiana uses DentaQuest dental services. Members can call DentaQuest at **1-844-234-9834 (TTY: 711)**, Monday – Friday from 7 AM to 7 PM CT.

Members do not need a referral to see a network dental provider. Members can find a dental provider in the provider directory online at **AetnaBetterHealth.com/Louisiana**.

Beginning on July 1, 2022, adults 21 years of age and older with developmental or intellectual disabilities who are enrolled in the New Opportunities Waiver, Residential Options Waiver or the Supports Waiver will receive access to the following services:

- Diagnostic services
- Preventive services
- Restorative services
- Endodontics
- Periodontics
- Prosthodontics
- Oral and maxillofacial surgery
- Orthodontics
- Emergency care

Adult Vision Benefits

Members do not need a referral to see an in-network vision provider. Members can find a vision provider in the provider directory online at **AetnaBetterHealth.com/Louisiana**. Aetna Better Health of Louisiana uses EyeMed for vision services. Members can call EyeMed at **1-888-747-0449 (TTY: 711)**, Monday through Saturday from 7 AM – 1 AM and Sunday 10 AM – 7 PM (Apr – Sep) or 7 MA – 1 AM (Oct – Mar) CST.

Covered services for adults 21 and over include a free annual eye exam through EyeMed and $150 toward eyewear (frames, glass, or contact lenses).

Mobile App

With the Aetna Better Health application, our members can get on demand access to the tools they need to stay healthy. It's easy. Member just downloads the app to their mobile device or tablet.

Mobile app features:

- Find a provider
- Request a Member ID card
- Change their PCP
- View their claims and prescriptions
- Message Member Services for questions or support
- Update their phone number, address, and other important member details

Download app: To get the mobile app, members can download it from Apple's App Store or Google's Play Store. Search for Aetna Better Health to locate the app. It is free to download and to use. This application is available on certain devices and operating systems (OS).

Maternity and Newborn Benefits

In addition to pregnancy tests available via the over-the-counter benefit, members can earn Promise reward gift cards before and after their baby is born through the My Maternity Matters benefit:

The more visits they make to their doctor during their pregnancy, the more rewards they can get.

- $25 gift card for completing Notice of Pregnancy form in the first trimester and completing first prenatal visit
- $10 gift card for each additional prenatal visit, up to 10 visits
- $25 gift card for postpartum visit (within 7 to 84 days after delivery)
- Pregnant members 18+ can earn a $10 gift card for each dental visit during pregnancy, Limit 2.
- New Mom Welcome Kit includes a diaper bag, pack of diapers and other baby related items, as well as pregnancy materials regarding baby care and healthy pregnancy resources that promotes the safety, health and well-being for babies and mothers.
- Baby Bundle for newborn members including a case (200) of diapers following live birth.
- High-risk pregnant members can receive $100 per quarter (every 3 months) to pay for child care so mom can go to doctor appointments.

The My Maternity Companions benefit also offers access to screenings, assessments, nutritional counseling, birth education and referrals to parental support programs for pregnant members and new mothers. Members can access up to 3 virtual prenatal visits, birth and after-birth classes, 3 virtual post-natal visits, 3 nutritional counseling sessions, and follow-up visits as needed.

Circumcisions are covered without the requirement of prior authorization up to 365 days of life. After 365 days, prior authorization is required.

Nurse line

Access to a nurse is available 24-hours a day, 7 days a week at **1-855-242-0802 (TTY: 711).**

Annual Wellness Incentives for Adults

Adults can earn gift cards after the member completes an adult checkup

- $10 gift card for completion of a Health Needs Assessment within 90 days of enrollment
- $5 gift card for receiving the annual flu shot
- $15 gift card after women's annual mammogram
- $20 gift card after annual diabetic blood testing with an HbA1c result under 8% for members with diabetes
- $15 gift card after annual cervical cancer screening
- $15 gift card for annual colorectal cancer screening
- $10 for an antipsychotic medication refill

Annual Wellness Incentives for Adolescents

Children and adolescents can earn gift cards after the member receives certain services:

- $15 gift card after 8 well child visits within the first 30 months of life
- $20 gift card for completion of an annual child or adolescent well-child visit for members aged 3-21
- $10 gift card for attending a medical appointment and fill/refill of prescribed ADHD medication

Blood Pressure Monitoring

Members receive a $10 gift card (limit 2 per year) for a high blood pressure medication refill. Members can also receive a free digital blood pressure monitor.

Asthma Home Benefit

Members with an asthma diagnosis who are also in case management can receive a home assessment that includes a comprehensive assessment and monitoring program, medication, patient education, control of triggers, and an Asthma Wellness Kit that includes items to help manage the member's condition.

Sickle Cell Benefit

Members diagnosed with sickle cell anemia receive the following incentives for chronic care management:

- $25 gift card to for scheduling and attending an appointment with a PCP or hematologist following initial post-discharge appointment
- $5 gift card for attending subsequent appointments, up to 5 incentives per year
- $10 gift card after filling a prescription for a sickle cell-related medication, up to 2 incentives per year excluding pain medication

Meals After an Inpatient Hospital Stay
Members receive two meals per day for up to 14 days post discharge for post-acute care.

Respite Care for Members Experiencing Homelessness
Members 18+ who were experiencing homelessness prior to hospitalization and are scheduled for discharge from an acute medical hospital with post-acute care needs can receive short-term room and board with wraparound health and social care services. Members also receive care coordination and case management services, health education, medication management, chronic disease management support, and support from an ABHLA housing specialist.

Alternatives to Opioids
Members aged 16+ with a chronic pain diagnosis have access to $500/year for alternative pain management options.

Help to stop smoking
Smoking cessation medications for up to six months and health coaching and phone counseling. Medications available for up to 6 months - Patch, gum, lozenge, nasal spray, inhaler, varenicline, bupropion. Identification of risk stratification through completion of the Health Risk Questionnaire, Outreach Assessment, and development of a member-centered Care Plan.

Utilization of educational resources such as mailings from Krames and active, one-on-one, engagement in development of a plan of care for any member willing to participate in the Care Management program to include Face-to-Face visits for any member in the Intensive Program.

Pyx Program for Social Isolation
The program includes access to the Pyx app that provides 24/7 self-management and support. Members also have direct access to a Pyx Health staff who are trained to help support members one-on-one when they screen as lonely, depressed, anxious, or indicate any social determinant of health need.

Trauma Calming Comfort
Members with high adverse childhood experiences (ACEs) or anxiety diagnosis can receive $50 worth of supplies per year to help calm the impact of trauma.

Afterschool Program Support
Members aged 5-16 years receive a credit of $50 per year towards afterschool programs at participating schools.

Career & Life Skills Training and HiSET Support
Members 16 and older have access to a job skills training platform and High School Equivalency Test (HiSET) prep and certifications as well as a voucher to cover the cost of the test.

Safe Home Program
Members receive in-home risks assessment to identify infestations, mold, utility interruptions, improper sewage drainage and treatment, and potential evections. Once needs are identified, ABHLA will connect members with remediation resources, including $1000/year to cover the cost of services, including legal services.

Free over-the-counter (OTC) medicine and products
Members receive a $25 monthly benefit per household for OTC vitamins and household and health products.

Enhanced Transportation

Members aged 18+ receive transportation services for activities such as job interviews, job training, trips to the grocery store or food bank, faith-based events, and accessing community support services not otherwise covered.

Nurses, social workers, and community health workers to help members manage their health and get access to the care they need.

Community Health Workers
ABHLA will cover services rendered to members by qualified community health workers (CHW) meeting the criteria and policy outlined below.

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. ABHLA will require providers who employ CHWs to verify and maintain and provide documentation, as requested by LDH, that qualification criteria are met.

Eligibility Criteria
ABHLA will cover CHW services if an enrollee has one or more of the following:

- Diagnosis of one or more chronic health (including behavioral health) conditions;
- Suspected or documented unmet health-related social need; or
- Pregnancy.

Covered services include:

- Health promotion and coaching. This can include assessment and screening for health-related social needs, setting goals and creating an action plan, on-site observation of member's living situations, and providing information and/or coaching in an individual or group setting.
- Care planning with the member and their healthcare team. This should occur as part of a person-centered approach to improve health by meeting a member's situational health needs and health-related social needs, including time-limited episodes of instability and ongoing secondary and tertiary prevention.
- Health system navigation and resource coordination services. This can include helping to engage, reengage, or ensure patient follow-up in primary care; routine preventive care; adherence to treatment plans; and/or self-management of chronic conditions.

Services must be ordered by a physician, advanced practice registered nurse (APRN), or physician assistant (PA) with an established clinical relationship with the member. 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.

ABHLA will not restrict the site of service which may include, but is not limited to, a health care facility, clinic setting, community setting, or the member's home. The health plan will permit delivery of the service through a synchronous audio/video telehealth modality. ABHLA will reimburse only the CPT procedure codes in the 'Education and Training for Patient Self Management' section that are provided by CHWs. The CHW are required to follow CPT guidance.

Coverage Limitations
ABHLA will not cover the following services when provided by CHWs:

- Insurance enrollment and insurance navigator assistance;
- Case management;
- Direct provision of transportation for a member to and from services; and
- Direct patient care outside the level of training an individual has attained.

ABHLA will reimburse a maximum of two hours per day and ten hours per month per member.

Reimbursement

ABHLA will reimburse CHW services "incident to" the supervising physician, APRN, or PA. A CHW who provides services to more than one member is required to document in the clinical record and bill appropriately using the approved codes associated with the number of people receiving the service simultaneously. This will be limited to eight unique members per session.

Community Health Workers in Federally Qualified Health Centers and Rural Health Clinics
Medicaid received approval from CMS to reimburse services rendered by qualified CHW in federally qualified health centers (FQHC) and rural health clinics (RHC) effective for dates of service on or after January 1, 2022. CHW service reimbursement is based on an alternative payment methodology, which allows reimbursement outside of the current Prospective Payment System rate for CHW services provided in FQHC and RHC settings. Providers will receive payment for services at the rate on file for the date of services as published on the Professional Service fee schedule on **www.lamedicaid.com.**

In order to be considered for reimbursement, FQHC and RHC claims for CHW service reimbursement may include all of the following:

- A HCPCS for the visit (T1015, H2020, or D0999);
- An evaluation and management code; and
- The corresponding CPT code for the CHW services to receive reimbursement.

If an evaluation and management code is included on the claim, reimbursement will be the rate on file for the encounter visit in addition to the rate on file for the CHW services for the date of service.

If an evaluation and management code is NOT included on the claim, reimbursement will be the rate on file for the CHW services for the date of service.

An evaluation and management visit must be conducted within 30 days of the CHW services.

The policy for CHW services is located in the Professional Services Provider Manual on **www.lamedicaid.com**. FQHC and RHC policy regarding billing of CHW services is located on **www.lamedicaid.com** in the respective provider manuals.

FFS system updates are pending, and this notice will be updated once system changes are implemented. Claims will be recycled upon implementation.

ABHLA will make system updates and recycle any claims that were paid incorrectly according to this change within 60 days of FFS system update implementation. ABHLA will also notify providers of the process and timeline for implementing the changes, as well as the plan to recycle impacted claims.

Medicaid Covered Services
Some services are covered by Medicaid but not by Aetna Better Health of Louisiana. Since these services are not covered by our Plan, you do not have to use our network providers to obtain these services.

Service	How to access
Coordinated System of Care (CSoC). This is a program for youth in out-of-home placement or at-risk of out-of-home placement.	Contact Magellan at **1-800-424-4489**.
Children's dental services	Contact either: MCNA Dental at **1-855-702-6262** TTY: **1-800-955-8771** Mon – Fri 7a – 7p, or visit **www.mcnala.net** DentaQuest at **1-800-685-0143** TTY: **1-800-466-7566** Mon – Fri 7a – 7p, or visit **www.dentaquest.net**
Nursing facility services	Contact Louisiana Options in Long Term Care at **1-877-456-1146**

Personal care services for members 21 and older, with the exception of Behavioral Health Personal Care Services	Contact Louisiana Options in Long Term Care at **1-877-456-1146**
ICF/DD Services	Contact the Office for Citizens with Developmental Disabilities at **1-866-783-5553**
All Home & Community-Based Waiver Services	Contact the Office for Citizens with Developmental Disabilities at **1-866-783-5553**
Targeted Case Management Services	Contact the Office for Citizens with Developmental Disabilities at **1-866-783-5553**
Services provided through LDH's Early-Steps Program (Individuals with Disabilities Education Act (IDEA) Part C Program Services)	Contact the Office for Citizens with Developmental Disabilities at **1-866-783-5553**
Individualized Education Plan (IEP) services provided by a school district	Contact the Louisiana Department of Education at **1-877-453-2721**
Medical Dental with the exception of the EPSDT varnishes provided in a primary care setting	Contact either: MCNA Dental at **1-855-702-6262** TTY: **1-800-955-8771** Mon – Fri 7a – 7p, or visit **www.mcnala.net** DentaQuest at **1-800-685-0143** TTY: **1-800-466-7566** Mon – Fri 7a – 7p, or visit **www.dentaquest.net**

Cost for Services

Aetna Better Health of Louisiana has a contract with Healthy Louisiana to provide health care services with no cost sharing. This means members should not be asked to pay copay when they receive medical services.

Non-Covered Services

There are some services that Aetna Better Health of Louisiana does not cover. These include:

- Services or items used only for cosmetic purposes
- Elective abortions
- Treatment for infertility
- Experimental/Investigational procedures drugs and equipment (Phase I & II Clinical Trials are considered experimental)

Post-Stabilization Services

Aetna Better Health of Louisiana covers post-stabilization services provided by a contracted or non-contracted provider in any of the following situations:

- When Aetna Better Health of Louisiana authorized the services
- Such services were administered to maintain the member has stabilized condition within one (1) hour after a request to Aetna Better Health of Louisiana for authorization of further post-stabilization services.
- When Aetna Better Health of Louisiana does not respond to a request to authorize further post-stabilization services within one (1) hour, could not be contacted, or cannot reach an agreement with the treating provider concerning the member's care and a contracted provider is unavailable for a consultation. In this situation, the treating provider may continue the member's care until a contracted provider either concurs with the treating provider's plan of care or assumes responsibility for the member's care.

Medical Necessity

Medical necessity is defined as a service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the provider in accordance with Aetna Better Health of Louisiana's guidelines, policies or procedures, for the diagnosis or treatment of a covered illness or injury, for the

prevention of future disease, to assist in the member's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.

You can view a current list of the services that require authorization on our website at **AetnaBetterHealth.com/Louisiana**. If you are not already registered for the secure web portal, download an application from the Louisiana Providers section of the site. If you have questions or would like to get training on the secure provider web portal and the Prior Authorization Requirement Search Tool, please contact our Provider Experience Department at **1-855-242-0802**.

Emergency Services

Aetna Better Health of Louisiana covers emergency services without requiring prior authorization for members, whether the emergency services are provided by a contracted or non-contracted provider. Aetna Better Health of Louisiana will cover emergency services provided outside of the contracting area except in the following circumstances:

- When care is required because of circumstances that could reasonably have been foreseen prior to the members departure from the contracting area
- When routine delivery, at term, if member is outside the contracting area against medical advice, unless the member is outside of the contracting area due to circumstances beyond her control. Unexpected hospitalizations due to complications of pregnancy are covered.

Aetna Better Health of Louisiana will abide by the determination of the physician regarding whether a member is sufficiently stabilized for discharge or transfer to another facility.

Pharmacy Services

You can find a more comprehensive description of covered services in **Pharmacy Management**.

Interpretation Services

Telephone interpretive services are provided at no cost to members or providers. Personal interpreters can also be arranged in advance. Sign language services are also available. These services can be arranged in advance by calling Aetna Better Health of Louisiana's Member Services Department at **1-855-242-0802**.

Transportation (Appointments vs Emergencies)

If the member has an emergency and has no way to get to the hospital, call 911 for an ambulance. If the member does not have transportation, we will cover transportation to medically covered services by Aetna Better Health of Louisiana. We will also cover transportation to Medicaid covered services such as dental care. We use a transportation vendor for member transportation needs. Transportation is provided to the visit and to the pharmacy, only when the member goes directly to the pharmacy immediately following the appointment.

There is no limit on the number of trips provided.

Transportation appointments must be scheduled three 48 hours in advance. Reservations can be made up to thirty (30) days in advance. Our transportation vendor will assist with ongoing transportation needs for services such as dialysis, or other re-occurring treatments. When making reservations, keep in mind that members should not arrive more than one hour before their scheduled appointment.

To schedule a ride, call our transportation vendor at **1-877-917-4150, TTY 1-866-288-3133**.

Please have these details ready when calling our transportation vendor:

- Name of the provider
- Provider's address
- Provider's telephone number
- Time of appointment
- Type of transportation needed (e.g., regular car, wheelchair-accessible van)

Emergency Ambulance Transportation

ABHLA does not require prior review or authorization for emergency ambulance transportation. Emergency ambulance transportation is provided for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

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

A member may also require emergency ambulance transportation if they are psychiatrically unmanageable or need restraint. ABHLA requires ambulance providers to retain documentation appropriately supporting at least one of the criteria was met and the enrollee would be susceptible to injury using any other method of transportation. An ambulance trip which does not meet at least one of the criteria would be considered a nonemergency service and must be coded and billed as such.

Air Transportation

Emergency air transportation does not require prior authorization. Providers must submit supporting clinical information with the claim for post-payment medical necessity review.

Prior authorization is required for non-emergency air ambulance transportation. Providers may submit a request for prior authorization through ABHLA's online Availity portal, fax, or phone. ABHLA will cover air ambulance services only if:

- Speedy admission of the member is essential and the point of pick-up of the enrollee is inaccessible by land vehicle or;
- Great distances or other obstacles are involved in getting the member to the nearest hospital with appropriate services

Non-Emergent Ambulance Transportation (NEAT)
Non-emergency ambulance transportation (NEAT) is transportation provided by ground or air ambulance to a member to and/or from a Medicaid covered service, including carved-out services, or VAB when no other means of transportation is available, and the member's condition is such that use of any other method of transportation is contraindicated or would make the member susceptible to injury.

Please note that **ALL** NEAT trips will require a completed, valid Certification of Ambulance Transportation (CAT). The beneficiary's treating physician, a registered nurse, the director of nursing at a nursing facility, a nurse practitioner, a physician assistant, or a clinical nurse specialist must certify on the Certification of Ambulance Transportation (CAT) that the transport is medically necessary and describe the medical condition, which necessitates ambulance services. The date range on the CAT must be no more than 180 days. A single CAT will be utilized by ABHLA for all the member's transports within the specified date range. ABHLA will not require a new CAT from the certifying authority for the same member during this date range.

Aetna requires the ambulance provider to verify member eligibility, the originating or destination address belongs to a medical facility, and a completed Certification of Ambulance Transportation form for the date of service is obtained, reviewed, and accepted by the ambulance provider prior to transport reimbursement. ABHLA will reimburse the ambulance provider only if a completed Certification of Ambulance Transportation form is submitted with the clean claim or is on file with ABHLA or the transportation broker prior to reimbursement. Mileage must be reimbursed in accordance with the type of service indicated by the licensed medical professional on the Certification of Ambulance Transportation.

To schedule NEAT, Members can call MediTrans at 1-877-917-4150, 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.

Providers may also reach MediTrans through email at ABHLA@meditrans.com or by phone at 1-844-349-4326. The Nonemergent Transportation Request Form can be found on our provider portal, and can be emailed to MediTrans or faxed to 1-337-366-6760. MediTrans may be contacted 24/7 for hospital discharges.

If transportation is scheduled through the ABHLA, ABHLA will verify enrollee eligibility, that the originating or destination address belongs to a medical facility, and that a completed Certification of Ambulance Transportation form for the date of service is obtained, reviewed, and accepted by ABHLA or the transportation broker prior to transport before a transport is scheduled. Once the trip has been dispatched to an ambulance provider and completed, the ambulance provider shall be reimbursed upon submission of the clean claim for the transport.

The Certification of Ambulance Transportation form is located at www.lamedicaid.com.

ABHLA's standards of Medical Necessity for Non-Emergency Ambulance Transportation are as follows:

- Medical necessity for ambulance service is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, no payment will be made for ambulance services.
- ABHLA considers the medical necessity requirement met when the beneficiary is bed-confined before the trip and expected to remain so after the trip. A beneficiary is bed-confined if he/she is:
    - unable to get up from a bed without assistance;
    - unable to ambulate; and
    - unable to sit in a chair or wheelchair.

Note that the term "bed confined" is not synonymous with "bed rest" or "non-ambulatory".

Non-Emergency Medical Transportation (NEMT)
Non-Emergency Medical Transportation (NEMT) is transportation provided to Medicaid enrollees to and/or from a Medicaid provider for a Medicaid covered service, including carved-out services and VAB, when no other means of

transportation are available. NEMT does not include transportation provided on an emergency basis, such as trips to emergency departments in life threatening situations.

Covered Services

ABHLA authorizes NEMT for the least costly means of transportation available to and/or from a qualified provider of routine or specialty care within the enrollee's transportation service area.

Scheduled trips in which no transportation of the enrollee occurs are not billable.

Reimbursement to transportation providers shall be no less than the published Medicaid fee-for-service rate in effect on the date of service, unless mutually agreed to by ABHLA and the transportation provider in the provider agreement.

Transportation to and from appointments for Medicaid covered services appointments and to extra services we offer such as adult dental care or a trip to the pharmacy after your appointment.

Exceptions: Enrollees may seek medically necessary services in another state when it is the nearest option available. All non-emergency out-of-state transportation must receive prior approval from ABHLA.

Commercial Air Transportation for Out-of-State Care

Transportation on commercial airlines may be approved for out-of-state trips when no comparable services can be provided in Louisiana, and the risk to the enrollee's health is grave if transported by other means. The transportation broker shall contact LDH if it determines that air travel is required, as commercial air transportation requires prior authorization. All out-of-state medical care must be prior authorized by the LDH fiscal intermediary. Transportation may be included in the prior authorization for medical services. Approval shall be contingent on the treating physician's confirmation that there are no negative impacts to the health and safety of the enrollee by utilizing commercial air transportation.

Air travel for the enrollee plus a maximum of one attendant, if medically necessary or if the enrollee is a child, shall be reimbursed for the lowest, refundable, coach/economy class fare. Upgrades (e.g., fare class or seat) and additional costs (e.g., in-flight refreshments) shall not be reimbursed.

Value Added Routine Transportation

Trips to the pharmacy are covered through value-added benefits (VABs). Effective 1/1/2023, Aetna will provide transportation to all applicable value-added services offered. Transportation services will be provided for activities such as job interviews, job training, trips to grocery stores or food banks, faith-based events, and accessing community support services not otherwise covered. Requests for transportation require 48 hours' advanced notice; trips scheduled with less than 48 hours' notice are not guaranteed, but an attempt will be made to provide the service if appropriate staff is available. Transportation to VABs is offered according to the benefit limitations. Limited to 10 round trips (20 one-way trips up to 60 miles total per round trip).

Ambulance Treatment in Place (TIP)

For Dates of Service on and after March 1, 2020:

The treatment-in-place service consists of a treatment-in-place ambulance service plus a treatment-in-place telehealth service. Each paid treatment-in-place ambulance service must have a corresponding paid treatment-in-place telehealth service and each paid treatment-in-place telehealth service must have a corresponding paid ambulance TIP service or paid corresponding emergent transport to a hospital facility.

Treatment-in-Place Ambulance Claim:

The treatment-in-place ambulance service must be separately billed from the treatment-in-place telehealth service. The ambulance provider's NPI must be enrolled as an ambulance service billing provider with the entity to whom the claim will be submitted (fee-for-service Medicaid or the MCO).

Supply codes A0382 and A0398 are payable but mileage (A0425) and other ambulance transportation services are not payable. If a treatment in place claim is submitted with mileage, the entire claim document will be denied. If an unpayable code, that is not mileage, is submitted on a treatment in place claim, only the line with the unpayable code should be denied.

Claims must indicate treatment-in-place destination code "W" in the destination position of the origin/destination modifier combination. TIP claims without Modifier "Y" to in the emergency indicator field will be denied by ABHLA.

Valid Treatment-in-Place Ambulance Claim Modifiers:

Modifier	Origination Site	Destination
DW	Diagnostic or therapeutic site other than P or H when these are used as origin codes	Tx-in-Place
EW	Residential, domiciliary, custodial facility (other than 1819 facility)	Tx-in-Place
GW	Hospital based ESRD facility	Tx-in-Place
HW	Hospital	Tx-in-Place
IW	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport	Tx-in-Place
JW	Freestanding ESRD facility	Tx-in-Place
NW	Skilled nursing facility	Tx-in-Place
PW	Physician's office	Tx-in-Place
RW	Residence	Tx-in-Place
SW	Scene of accident or acute event	Tx-in-Place

If a patient being treated in place has a real-time deterioration in their clinical condition necessitating immediate transport to an emergency department, the ambulance provider cannot bill for both the treatment in place ambulance service and the transport to the emergency room. In that case, the **ambulance provider shall bill only for the emergency department transport**.

Requests for consideration or reconsideration of these claim denials (edit 90/100) for multiple treatment in place and treatment in place and transport claims rendered on the same date of service for the same recipient, should be submitted with a **Prehospital Care Report from the ambulance service provider's system** demonstrating the services were rendered for different occurrences. Aetna Better Health of Louisiana uses the Call # on the report to differentiate multiple claims and will deny such claims where the report is not attached. Mail hard copy claim to:

Aetna Better Health of Louisiana
P.O. Box 982962
El Paso, TX 79998-2962

Optional Procedure Code for Patient's Refusal to Participate in ET3 Model Interventions

For informational purposes, ambulance providers may include **G2022** on ambulance transportation claims to an ER that met ET3 model but the member refused TIP and transportation to alternative destination (TAD). ABHLA will pay such claims at $0.00.

Optional				
Procedure Code	**Description**	**When to use it**	**Where to use it**	**Fee**
G2022	Beneficiary refuses treatment in place services	Ambulance transport claims to an ER that met TIP or TAD criteria, but the patient refused.	CPT/HCPCS Code Field	$0.00

Treatment-in-Place Telehealth Claims:
Treatment-in-place telehealth services must be separately billed from treatment-in-place ambulance services. Claims for allowable telehealth procedure codes must be billed with **the addition of G2021 procedure code**. The G2021 code will be accepted, paid at $0.00 and used by Medicaid to identify treatment-in-place telehealth services. Please see details in the chart below.

As with all telehealth claims, providers must include POS identifier of "02" and modifier "95" with their claim to identify the claim as a telehealth service. Providers must follow CPT guidance relative to the definition of a new patient versus an established patient.

Procedure Code	Modifier	Place of Service	Description	When to use it	Where to Use It	Fee
G2021	95	02	TIP telehealth service	When providing TIP telehealth services	CPT/HCPCS Code Field; Must be used when Providers bill claims for the telehealth service.	$0.00

Billing & Rendering Providers
The Billing Provider's NPI must be enrolled as a professional service billing provider with the entity to whom the claim will be submitted (fee-for-service Medicaid or the MCO).
The rendering provider's NPI must be reported on the claim for both the E/M telehealth procedure code and the G2021 procedure code[2] and must be enrolled with the entity to whom the claim will be submitted (fee-for-service Medicaid or the MCO). Valid rendering providers are licensed physicians, advanced practice registered nurses, and physician assistants. Rendering providers must be 'linked' to the billing provider.

Approved Telehealth Procedure Codes:

Category	Service	CPT Codes
Evaluation and Management, Office, or Other Outpatient Service	New Patient	99201[3] , 99202, 99203, 99204, 99205
	Established Patient	99211, 99212, 99213, 99214, 99215

Recap:
ABHLA will enact edits to match ambulance TIP claims to the corresponding TIP telehealth claims and telehealth TIP claims to either ambulance TIP or ambulance transport.
There should be:

- no telehealth TIP without a corresponding ambulance TIP or ambulance transport.
- no ambulance TIP without a corresponding telehealth TIP service.

Ambulance treatment in place encounters without a corresponding telehealth encounter will be denied.
Claims for multiple treatment in place and treatment in place and transport claims rendered on the same date of service for the same recipient, submitted without Pre-Hospital Care Summary Reports will be denied.
Claims for TIP without modifier "Y" in the emergency indicator field will be denied.

NEMT Issue Resolution
Providers experiencing issues with claims related to transportation brokers, must first seek a resolution directly via the transportation broker rather than contacting Aetna Better Health of Louisiana, third parties, or the Louisiana Department of Health (LDH).

Should you experience issues with ABHLA's transportation broker, One Call, please contact them directly to resolve transportation claims issues:

MediTrans

Contact	Phone	Email
Claims Escalation - Carolyn Banks	844-349-4326	Llewis@meditrans.com

[2] Rendering provider NPI is required when it is different than the billing provider, ASCX 12N/5010X222
[3] Procedure code 99201 deleted effective with DOS 01-01-2021

Billing Department		Billing@meditrans.com

Claim Appeal
Claim appeals must be received from the provider within 180 calendar days of the Remittance Advice paid date or the original denial date. A determination will be made by the broker within 30 days of receipt. Use the contact information below to submit requests:

MediTrans:
By phone: 844-349-4326
By email: Billing@meditrans.com

Formal Complaints
The following resolution options are available for all issue types, including claims. Providers should use the following contact information for complaints and escalation of issues through ABHLA:

Escalation Type	Contact Information
Formal Complaint	**By phone: 1-855-242-0802** **By email: LAProvider@aetna.com** **By mail:** Aetna Better Health of Louisiana 2400 Veterans Memorial Blvd. Suite 200 Kenner, LA 70062
Management Level Contact	Stella Joseph, Manager of Appeal and Grievance **LAAppealsandGrievances@aetna.com**
Executive Level Contact	Richard Born, CEO **BornR@aetna.com**

Formal Complaints through LDH
In the event a provider is not satisfied with the resolution or does not receive a timely response from ABHLA, the provider can contact LDH directly using the following contact information:

Email: MedicaidTransportation@la.gov

NOTE: Include detailed information on all attempts to resolve the issue through ABHLA, as well as contact information (contact name, provider name, e-mail, and phone number) of ABHLA staff. This will allow LDH staff to follow up with any questions.

Independent Review
Providers may also use Independent Review in conjunction with the claim appeals options in this notification. This option is available for resolution of all claim disputes. The Independent Review process may be initiated after claim denial.

NOTE: Per House Bill No. 492 Act No. 349, an adverse determination involved in litigation or arbitration or not associated with a Medicaid enrollee shall not be eligible for independent review.

- The Independent Review process was established by La-RS 46:460.81, et seq. to resolve claims 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 (2) step process which may be initiated by submitting an Independent Review Reconsideration Request Form to the MCO within 180 calendar days of the Remittance Advice paid, denial, or recoupment date. Request forms are available on MCO websites or at http://ldh.la.gov/index.cfm/page/2982.
- If a provider remains dissatisfied with the outcome of an Independent Review Reconsideration Request, the provider may submit an Independent Review Request Form to LDH within 60 calendar days of the MCO's decision. Request form available at the link below.

- Effective Jan. 1, 2018, 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. Conversely, if the independent reviewer finds in favor of the MCO, the provider is responsible for paying the fee.
- SIU post-payment reviews are not considered claims denials or underpayment disputes; therefore, SIU findings are exempt from the Independent Review Process.
- Additional detailed information and copies of above referenced forms are available at: http://ldh.la.gov/index.cfm/page/2982

MCO Physician Directed Post Payment Review Guidelines

The treatment-in-place service consists of a treatment-in-place (TIP) ambulance service plus a treatment-in-place telehealth service. Each paid treatment-in-place ambulance service must have a corresponding paid treatment-in-place telehealth service and each paid treatment-in-place telehealth service must have a corresponding paid ambulance TIP service or paid corresponding emergent transport to a hospital facility.[4]

Allow 365 business days to elapse from the date of service of the first paid claim before initiating investigations.

Identification of Ambulance TIP Claims/Encounters:

Ambulance TIP procedure codes are identifiable by procedure codes A0427 or A0429 with W destination modifier is W.[5]

Ambulance TIP claims/encounters are restricted to those on the Physician-Directed Ambulance Treatment-in-Place Fee schedule: **www.lamedicaid.com/Provweb1/fee_schedules/PDA_TIP.pdf**

Identification of Telehealth TIP Claims/Encounters:

Telehealth TIP service claims/encounters are billed using E&M codes with place of service 02, modifier 95 and procedure code G2021. G2021 claim line identifies the claim as a telehealth treatment in place service. Telehealth procedure codes billed without G2021 should be excluded from the match.

Telehealth TIP payable procedure codes are restricted to those found in the Treatment-In-Place (TIP) Telehealth Services Fee Schedule: **www.lamedicaid.com/Provweb1/fee_schedules/TIP_Tellhealth.pdf**

[4] If a patient being treated in place has a real-time deterioration in their clinical condition necessitating immediate transport to an emergency department, the ambulance provider cannot bill for both the treatment in place ambulance service and the transport to the emergency room. In that case, the ambulance provider shall bill only for the emergency department transport.

[5] Origin and destination codes used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of "X", represents an origin code or a destination code. The pair of alpha codes creates one code to be reported in modifier field. The first position alpha code equals origin; the second position alpha code equals destination.

Mental Health/Substance Use Disorder Services

Behavioral health is defined as those services provided for the assessment and treatment of problems related to mental health and substance use disorders. Substance use disorders include overuse of alcohol and other drugs. In order to meet the behavioral health needs of our members, Aetna Better Health of Louisiana will provide a continuum of services to members at risk of or suffering from mental, addictive, or other behavioral disorders. We are an experienced behavioral health care organization and have contracted with behavioral health providers who are experienced in providing behavioral health services to the Louisiana population.

Specialized Behavioral health services is a covered benefit for Aetna Better Health members. Additional benefits may be available for ABHLA members for those who qualify. Providers can call the toll-free number located on the back of the member's identification card to access information about services, participating behavioral health providers and authorization information for members who request services from a behavioral health provider directly.

In addition, for all categories of members, Aetna Better Health of Louisiana will cover the diagnoses of diseases of organic origin categorized as altering the mental status of a member.

Aetna Better Health of Louisiana's Chronic Care Management Program ICM Objective:

- Provides an integrated approach to physical and behavioral health conditions that also addresses psychosocial circumstances, which is critical to helping our most vulnerable and highest risk members
    - Engages member and care providers to enhance care outcomes
    - Works as an interdisciplinary team that combines core competencies in physical and behavioral health within a systems framework to manage psycho-social complexity and challenging relationships with members and their families
- Focuses on member health and well-being using behavioral change strategies, relationship building and engaging community and social systems to wrap around the member to enhance resiliency and self-efficacy
- Starts with assessing members as they are identified, evaluating them as "whole" beings, and including all elements surrounding them that may impact their health status
- Assigns to an appropriate level of intervention intensity, and staff will team with them in managing their care
- Tools and services assist in decreasing the need for invasive care and increasing self-management to improve health and well-being
- Establish a collaborative working relationship with providers in each region of the state
- Identify strengths: Assure we neither duplicate nor disrupt what is working well
- Identify and prioritize gaps in the local array of services and supports each members needs and conditions in general and priority populations in particular
- Identify and respond to opportunities for training and technical assistance to support providers

Effective 8/1/2024, CMS approved for Medicaid reimbursement of services delivered by provisionally licensed counselors (PLPC), provisionally licensed marriage and family therapists (PLMFT), and licensed master social workers (LMSW). Allowable procedures and rates can be found on the Specialized Behavioral Health Services (SBHS) fee schedule and Informational Bulletin 24-25.

Provider Network Monitoring Program

It is the policy of ABHLA to measure compliance with LDH Behavioral Health Provider Network Monitoring Standards. The Behavioral Health Provider Network Monitoring Process will aim to maintain a network of qualified providers through review, analysis, and evaluation of provider and staff personnel records and other administrative records.

ABHLA requires ongoing monitoring of provider qualifications and requirements of a representative sample size of all in-network Specialized Behavioral Health Service (SBHS) providers to ensure compliance with established state and federal guidelines and regulations.

- SBHS providers sampled with an overall score below 100% must be reported detailing deficiencies.

- SBHS providers sampled must meet 100% overall for provider qualifications and requirements or be subject to a corrective action plan.
- SBHS providers sampled have 15 days to correct identified deficiencies and submit documentation demonstrating compliance.
- Pursuant to LA R.S. 46:460.73, reimbursement for any services provided during the fifteen-day remedy period after notice of the deficiency was identified by ABHLA, or during a longer period if allowed by LDH, will be withheld if the provider elects to continue providing services while the deficiency is under review.
- If the deficiency is remedied, ABHLA will remit payment to the provider.
- If the deficiency is not remedied, nothing in this Subsection shall be construed to preclude ABHLA from recouping funds from the provider for any period in which the provider was not properly enrolled, credentialed, or accredited.
- Providers not demonstrating compliance after the **15 days period** will be referred for non-compliance to the appropriate department per ABHLA policies and procedures.
- Provider records are to be maintained in a manner that is current, detailed, organized, and which permits effective quality review.

The Provider Network Monitoring Review will include the following but is not limited to: requirements associated with licensure, accreditation, educational and professional experience, staffing requirements, and training as established by Medicaid provider policy manuals as well as accuracy of provider demographics associated with service location addresses, telephone numbers, languages spoken, current staff rosters and status of accepting new Medicaid referrals, as compared against ABHLA credentialing files and the ABHLA provider directory listings. Providers will be reviewed based on the services for which they have received reimbursement and no more than once within the calendar year, unless ABHLA has identified cause for a re-review.

Emergency Certificates for Inpatient or Residential Behavioral Health Services

Aetna Better Health of Louisiana is required to pay claims for behavioral health services provided to enrollees committed under an emergency certificate to an inpatient or residential facility regardless of medical necessity for a maximum period of 24 hours from the time of admission to the inpatient or residential facility, as long as the following conditions are met:

- The admitting physician and the evaluating psychiatrist or medical psychologist must offer the subject of the emergency certificate the opportunity for voluntary admission; and
- Any person committed under an emergency certificate must be evaluated by a psychiatrist or medical psychologist in the admitting facility within 24 hours of arrival at the admitting facility.

After the psychiatric evaluation has been completed, payment of claims must be determined by medical necessity. If the subject of the emergency certificate does not receive a psychiatric evaluation within the required timeframe, Aetna Better Health of Louisiana is only required to pay behavioral health claims within the first 24 hours of admission. Payment for any subsequent claim must be determined by medical necessity.

Telehealth Services

Substance Use Disorder Services

LMHP's providing assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services within intensive outpatient or outpatient treatment may be reimbursed when conducted via telecommunication technology. The LMHP is responsible for acting within the telehealth scope of practice as decided by the respective licensing board. The provider must bill the procedure code (CPT codes) with modifier "95", as well as the correct place of service, either POS 02 (other than home) or 10 (home). Reimbursement will be at the same rate as a face-to-face service. Exclusions: Methadone admission visits conducted by the admitting physician within Opioid Treatment Programs are not allowed via telecommunication technology.

Opioid Treatment

LMHP's providing assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services offered within Opioid Treatment Programs may be reimbursed when conducted via telecommunication technology. The LMHP is responsible for acting within the telehealth scope of practice as decided by the respective licensing board. The provider must bill the procedure code (CPT codes) with modifier "95", as well as

the correct place of service, either POS 02 (other than home) or 10 (home). Reimbursement will be at the same rate as a face-to-face service. Exclusions: Methadone admission visits conducted by the admitting physician within Opioid Treatment Programs are not allowed via telecommunication technology.

Applied Behavior Analysis

ABHLA will reimburse the use of telehealth, when appropriate, for rendering certain ABA services for the care of new or established patients or to support the caregivers of new or established patients.

Telehealth requires prior authorization for services. Subsequent assessments and behavior treatment plans can be performed remotely via telehealth only if the same standard of care can be met. Previously approved prior authorizations can be amended to increase units of care and/or to reflect re-assessment goals.

The following codes can be performed via telehealth; however, requirements for reimbursement are otherwise unchanged from in-person ABA. Relevant CPT codes include: 97151, 97155, 97152, 97156, 97153, 97157, 97154, 97158. ABA services rendered via telehealth must have the appropriate place of service indicated (02-other than home or 10-home) based on the member's location at the time of service. CPT codes must also be appended with modifier -95.

Telehealth services must be based on ABA methodology and rendered or directed by a registered line technician (RLT), licensed behavior analyst (LBA), or certified assistant behavior analyst (CaBA). The caregivers/patients and RLT/LBA/CaBA must be linked through an interactive audio/visual telecommunications system. The purpose of this service is to provide family adaptive behavior treatment guidance, which helps parents and/or caregivers properly use treatment procedures designed to teach new skills and reduce challenging behaviors.

Telehealth supervision of in-home therapy rendered by a RLT must utilize an LBA/CaBA to provide remote supervision. Each RLT must obtain ongoing supervision as approved in the patient's plan of care. Supervision may be conducted via telehealth in lieu of the LBA/CaBA being physically present. The purpose of supervision is to improve and maintain the behavior analytic, professional, and ethical repertoires of the RLT and facilitate and maintain the delivery of high-quality services to his or her patients.

The licensed supervising professional should supervise no more than 24 technicians a day. More technicians may be supervised if a CaBA is part of the professional support team or depending on the mix of needs in the supervisor's caseload. The licensed professional can supervise no more than 10 CaBAs.

The following services do not meet medical necessity criteria, and do not qualify as Medicaid covered ABA-based therapy services:

- Therapy services rendered when measurable functional improvement or continued clinical benefit is not expected, and therapy is not necessary or expected for maintenance of function or to prevent deterioration;
- Service that is primarily educational in nature;
- Services delivered outside of the school setting that duplicate services under an individualized family service plan (IFSP) or an IEP, as required under the federal Individuals with Disabilities Education Act (IDEA);
- Treatment whose purpose is vocationally or recreationally-based; and
- Custodial care that:
    - Is provided primarily to assist in the activities of daily living (ADLs), such as bathing, dressing, eating, and maintaining personal hygiene and safety;
    - Is provided primarily for maintaining the safety of the beneficiary or anyone else; or
    - Could be provided by persons without professional skills or training.

Behavioral Health In Lieu of Services

Behavioral Health In Lieu of Services

In Lieu of (ILO) Service	Medicaid State Plan services(s)
23-Hour observation bed services for adult age 21 and older to allow for assessment to decide need for admission.	Inpatient Psychiatric Hospitals
Free standing psychiatric hospitals for adults ages 21-64 creates treatment beds outside the hospital and is less costly.	General Hospital Psychiatric units
Injection services provided by a licensed nurse to adults ages 21 and older for psychotropics medication to ensure compliance and stability.	Physician Services

Mental Health Intensive Outpatient Programs (IOP) to provide treatment in the least restrictive level of care, allowing an alternative to Inpatient hospitalization or Assertive Community Treatment and providing a step-down option from inpatient hospitalization for members at high risk for readmission	Inpatient Psychiatric Hospitals
Therapeutic day center for ages 5-20 provide intensive mental health supports to reduce incidents of crisis hospitalization and residential psychiatric care.	Inpatient Psychiatric Hospitals and Psychiatric Residential Treatment Facilities

Therapeutic Day Center (ILO)

The Center for Resilience is a therapeutic day center in New Orleans which provides educational and intensive mental health supports to children and youth ages 5-20 in an innovative partnership with the Tulane University Medical School Department of Child and Adolescent Psychiatry to ensure the emotional well-being and academic readiness of children with behavioral health needs. Children receive instructional, medical, and therapeutic services at the day program site with the goal of building the skills necessary to successfully transition back to the traditional school setting. Center for Resilience provides a caring, non-punitive, therapeutic milieu with positive behavioral supports, trauma-informed approaches, evidence-based mental health practices, small-group classroom instruction, and therapeutic recreation activities.

Transcranial Magnetic Stimulation (TMS)

Effective 8/2/2024, TMS is covered for treatment of major depression only. TMS can be performed in an office setting and is considered medically necessary when all of the following criteria are met:

1. Member is 18 years of age or older; AND
2. Diagnosis of major depressive disorder (DSM 5 diagnostic terminology); AND
3. Failure or intolerance to psychopharmacologic agents, choose ONE of the following:
    a. Failure of psychopharmacologic agents, BOTH of the following:
        i. Lack of clinically significant response in the current depressive episode to four trials of agents from at least two different agent classes; AND
        ii. At least two of the treatment trials were administered as an adequate course of mono- or poly-drug therapy with antidepressants, involving standard therapeutic doses of at least six weeks duration.
    b. The member is unable to take anti-depressants due to ONE of the following:
        i. Drug interactions with medically necessary medications; OR
        ii. Inability to tolerate psychopharmacologic agents, as evidenced by trials of four such agents with distinct side effects in the current episode; AND
4. No contraindications to TMS are present (see section on contraindications); AND
5. Electroconvulsive therapy has previously been attempted, is medically contraindicated, or has been offered and declined by the member.

Retreatment is considered medically necessary when all of the following criteria have been met:

1. Current major depressive symptoms have worsened by 50 percent from the prior best response of the PHQ-9 score; AND
2. Prior treatment response demonstrated a 50 percent or greater reduction from baseline depression scores; AND
3. No contraindications to TMS are present (see section on contraindications).

Contraindications:

- Individuals who are actively suicidal;
- Individuals with a history of or risk factors for seizures during TMS therapy;
- Individuals with vagus nerve stimulators or implants controlled by physiologic signals, including pacemakers, and implantable cardioverter defibrillators;
- Individuals who have conductive, ferromagnetic, or other magnetic-sensitive metals implanted in their head within 30 cm of the treatment coil (e.g., metal plates, aneurysm coils, cochlear implants, ocular implants, deep brain stimulation devices, and stents);

- Individuals who have active or inactive implants (including device leads), including deep brain stimulators, cochlear implants, and vagus nerve stimulators;
- Individuals with active psychoses or catatonia where a rapid clinical response is needed.
- History of seizure disorder except seizures induced by ECT.
- Metal implants or devices present in the head or neck.
- Substance use at the time of treatment.
- Diagnosis of severe dementia.
- Diagnosis of severe cardiovascular disease

A referral from a psychiatrist is required and must be submitted prior to treatment.

Mental Health Intensive Outpatient Services (MH IOP)
For ages 12 and over, ABHLA covers Mental Health Intensive Outpatient (MH IOP) services as in in lieu of benefit, which are psychiatric intensive outpatient services provided for a minimum of 6 hours per week for adolescents and 9 hours per week for adults. MH IOP is a psychiatric hospital based service and providers must follow the guidelines listed in the LDH Hospital Services Provider Manual (Chapter 25 of the Medicaid Services Manual). There is a ten to one ratio for therapy groups and the treatment team should have a licensed mental health provider (LMHP), psychiatrist, and nurse on staff. All members are seen a minimum of monthly by the LMHP or psychiatrist but are seen more frequently as needed for medication changes or increased symptoms. Staff working with adolescent members (aged 12-17) must have received training specific to that population, incorporate family therapy and age-appropriate evidence based practices into their treatment plan, and allow members to participate in school. Prior authorization is required, and services can be approved for up to 30 days at a time.

Substance Use Disorder Intensive Outpatient Services (SUD IOP)
For Substance Use Disorder Intensive Outpatient Treatment, HCPC code H0015 may not be billed for more than one unit per day. Please note the following parameters for the appropriate provision and billing of SUD IOP per the **LDH Behavioral Health Services Provider Manual (Chapter 2 of the Medicaid Services Manual**):

- Adult IOP group must consist of a minimum of 3 hours per day, for a minimum of 3 days per calendar week (9 contact hours) and a maximum of 5 days per calendar week.
- Youth IOP group must consist of a minimum of 3 hours per day, for a minimum of 2 days per calendar week (6 contact hours) and a maximum of 5 days per calendar week.
- For both youth and adults receiving SUD IOP, a minimum of 1 session of individual therapy must be provided within each 30-day service period, with a maximum of 4 sessions per 30-day service period.
- The maximum number of SUD IOP treatment hours for adolescents and adults is 19 hours per week.

Availability
Mental Health/Substance Use Disorder (MH/SUD) providers must be accessible to members, including telephone access, 24 hours a day, and 7 days per week in order to advise members requiring urgent or emergency services. If the MH/SUD provider is unavailable after hours or due to vacation, illness, or leave of absence, appropriate coverage with other participating providers must be arranged. Mental Health/Substance use disorder (MH/SUD) providers are required to meet our contractual standards for urgent, emergent, and routine behavioral health appointments. For a complete list, please see **Appointment Availability Standards**.

Urgent and Emergent Care
Urgent Care providers must have availability within twenty-four (24) hours of member notification of the existence of an urgent condition. Provisions must be available for obtaining urgent care 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by the MCO through other arrangements. An appointment shall be arranged within forty-eight (48) hours of request.

Providers must deliver emergent or emergency visits immediately upon behavioral health member presentation at the service delivery site. Emergent, crisis or emergency behavioral health services must be available at all times and an appointment shall be arranged within one (1) hour of request.

For urgent non-emergency behavioral health care, providers must have availability with forty-eight (48) hours of member request.

Referral Process for Members Needing Mental Health/Substance Use Assistance
Members will be able to self-refer to any participating MH/SUD provider with our network without a referral from their Primary Care Provider (PCP).

Primary Care Provider Referral
We promote early intervention and health screening for identification of behavioral health problems and patient education. To that end, Aetna Better Health of Louisiana providers are expected to:

- Screen, evaluate, treat, and refer (as medically appropriate), any behavioral health problem/disorder;
- Treat mental health and substance use disorders within the scope of their practice;
- Inform members how and where to obtain behavioral health services; and
- Understand that members may self-refer to an Aetna Better Health of Louisiana behavioral health care provider without a referral from the member's Primary Care Provider (PCP).

Coordination Between Behavioral Health and Physical Health Services
We are committed to coordinating medical and behavioral care for members who will be appropriately screened, evaluated, treated, and referred for physical health, behavioral health. With the member's permission, our case management staff can facilitate coordination of case management related substance use screening and behavioral health evaluation, and treatment.

Members seen in the primary care setting may present with a behavioral health condition, which the PCP must be prepared to recognize. Primary Care Providers (PCPs) are encouraged to use behavioral health screening tools, treat behavioral health issues that are within their scope of practice and refer members to behavioral health providers when appropriate. Members seen by behavioral health providers are screened for co-existing medical issues. Behavioral health providers will refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member's consent. Behavioral health providers may only provide physical health care services if they are licensed to do so. Mental Health/Substance use (MH/SUD) providers are asked to communicate any concerns regarding the member's medical condition to the PCP, with the members consent if required, and work collaboratively on a plan of care.

Information is shared between Aetna Better Health of Louisiana and participating behavioral health and medical providers to verify interactions with the member result in appropriate coordination between medical and behavioral health care.

The Primary Care Provider and behavioral health provider are asked to share pertinent history and test results within 24 hours of receipt of results in urgent or emergent cases, and notification within 10 business days of receipts of results for non-urgent or non-emergent lab results. Members will be able to self-refer to any participating MH/SUD provider with our network without a prior authorization or a referral from their PCP.

Routine, non-urgent, or preventative care visits shall be arranged within 6 weeks. For behavioral healthcare, routine, non-urgent appointments shall be arranged within fourteen (14) days of referral.

Behavioral Health Services in FQHCs and RHCs
See **Behavioral Health Services Claims (FQHCs and RHCs)** for specific billing requirements for behavioral health services provided in Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs).

Act 503: Community Psychiatric Support and Treatment and Psychosocial Rehabilitation Services
Act 503, effective January 1, 2023, revises components of community psychiatric support and treatment (CPST) and psychosocial rehabilitation (PSR) services and the staff able to provide such services. Act 503 defines "community psychiatric support and treatment services" as CMS-approved Medicaid mental health rehabilitation services designed to reduce disability from mental illness, restore functional skills of daily living, build natural supports, and achieve identified person-centered goals or objectives through counseling, clinical psycho-education, and ongoing

monitoring needs as set forth in an individualized treatment plan. "Psychosocial rehabilitation services" means CMS-approved Medicaid mental health rehabilitation services designed to assist the individual with compensating for or eliminating functional deficits and interpersonal or environmental barriers associated with mental illness through skill building and supportive interventions to restore and rehabilitate social and interpersonal skills and daily living skills.

Any individual rendering the assessment and treatment planning components of CPST services for a licensed and accredited provider agency shall be a fully licensed mental health professional. Any individual rendering any of the other components of CPST services for a licensed and accredited provider agency shall be a fully licensed mental health professional, a provisionally licensed professional counselor, a provisionally licensed marriage and family therapist, a licensed master social worker, a certified social worker, or a psychology intern from an American Psychological Association approved internship program.

Any individual rendering PSR services for a licensed and accredited provider agency will hold a minimum of one of the following:

- A bachelor's degree from an accredited university or college in the field of counseling, social work, psychology, sociology, rehabilitation services, special education, early childhood education, secondary education, family and consumer sciences, criminal justice, or human growth and development;
- A bachelor's degree from an accredited university or college with a minor in counseling, social work, sociology, or psychology; or
- Be twenty-one (21) years of age or older as of January 1, 2022, have a high school diploma or equivalent, and have been continuously employed by a licensed and accredited agency providing PSR services since prior to January 1, 2019.

Once Act 503 is implemented, only the above listed provider types can render and will be reimbursed for CPST and PSR services.

Provider Assessments

On an annual basis, Aetna Better Health of Louisiana along with other Managed Care Organizations (MCOs) will conduct an assessment of practice integration using the Integrated Practice Assessment Tool (IPAT) on those providers who are likely to interface with the behavioral health populations.

Medical Records Standards

Medical records must reflect all aspects of patient care, including ancillary services. Participating providers and other health care professionals agree to maintain medical records in a current, detailed, organized, and comprehensive manner in accordance with customary medical practice, applicable laws, and accreditation standards. Medical records must reflect all aspects of patient care, including ancillary services. Detailed information on Medical Records Standards can be found in **Medical Records Review**.

Mental Health Parity and Addition Equality Act (MHPAEA)

The Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted to verify "parity" or fairness between mental health and substance use disorder (MH/SUD) benefits and medical/surgical benefits covered by a Managed Care Organization (MCO) such as Aetna Better Health of Louisiana. Enacted in 2008, MHPAEA does not require an (MOC) to offer MH/SUD benefits, but if the plan does so, it must offer the benefits on par with the other medical/surgical benefits it covers. In 2010, The Departments of Treasury, Labor, and Health and Human Services issued Interim Final Regulations (IFR) implementing the law. On Friday November 8, 2013, the Departments issued a Final Rule (FR) implementing the law.

A simple example of a parity requirement would be the frequency of office visits. Under MHPAEA, a plan may not allow a patient to have an unlimited number of medically necessary appointments with a dermatologist, but limit patients to only 5 appointments with a psychiatrist. However, while the premise of the law seems simple, the regulations related to the law are quite complicated, and therefore, implementation of the law has been complicated. This brief summary of the law is intended to help providers understand the law and the rights it affords them.

Links to Key Materials

- Final regulation, available at **www.dol.gov/ebsa/pdf/mhpaeafinalrule.pdf**
- Interim Final Regulation, available at **www.dol.gov/ebsa/mentalhealthparity/**
- FAQs about ACA Implementation Part XVII and Mental Health Parity Implementation, available at **www.dol.gov/ebsa/faqs/faq-aca17.html**
- U.S. Department of Health and Human Services' Study: Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, available at **www.dol.gov/ebsa/pdf/hhswellstonedomenicimhpaealargeemployerandghpbconsistency.pdf**
- News release, available at h**ttp://www.dol.gov/ebsa/newsroom/2013/13-2158-NAT.html**
- CMS January 16, 2013 letter to State Health Officials and Medicaid Directors, available at **www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf**
- CMS overview document **www.cms.gov/regulations-and-guidance/health-insurance-reform/healthinsreformforconsume/downloads/mhpaea.pdf**
- **www.aetnabetterhealth.com/louisiana/providers/index.html**

Aetna Better Health of Louisiana is committed to treating members with respect and dignity at all times. Member rights and responsibilities are shared with staff, providers, and members each year, with new members upon enrollment, and new providers upon joining our network.

Treating a member with respect and dignity is good business for the provider's office and often can improve health outcomes. Your contract with Aetna Better Health of Louisiana requires compliance with member rights and responsibilities, especially treating members with respect and dignity. Understanding member' rights and responsibilities are important because you can help members to better understand their role in and improve their compliance with treatment plans.

It is Aetna Better Health of Louisiana's policy not to discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis that is prohibited by law. Please review the list of member rights and responsibilities below. Please see that your staff is aware of these requirements and the importance of treating members with respect and dignity.

In the event that Aetna Better Health of Louisiana is made aware of an issue with a member not receiving the rights as identified above, Aetna Better Health of Louisiana will initiate an investigation into the matter and report the findings to the Quality Management Committee and further action may be necessary.

In the event Aetna Better Health of Louisiana is made aware of an issue when the member is not demonstrating the responsibilities as outlined above, Aetna Better Health of Louisiana will make good faith efforts to address the issue with the member and educate the member on their responsibilities.

Members have the following rights and responsibilities:

Member Rights

Members, their families, and guardians have the right to information related Aetna Better Health of Louisiana, its services, its providers and member rights and responsibilities in a language they can understand.

Members have the following rights:

- To be treated with respect and with due consideration for his/her dignity and privacy
- Privacy when you are at an office visit, getting treatment or talking to the health plan. Have your privacy protected.
- Know if your health information was shared without your okay
- To participate in decisions regarding his/her health care, including the right to refuse treatment for religious and any other reason
- To a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in the Federal regulations on the use of restraints and seclusion
- To be able to request and receive a copy of his/her medical records, (one copy free of charge) and request that they be amended or corrected
- To receive health care services that are accessible, are comparable in amount, duration, and scope to those provided under Medicaid Fee-For-Service and are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition
- To receive all information — e.g., enrollment notices, informational materials, instructional materials, available treatment options and alternatives — in a manner and format that may be easily understood as defined in the Contract between LDH and Aetna Better Health of Louisiana

- To receive assistance from both LDH and the Enrollment Broker in understanding the requirements and benefits of Aetna Better Health of Louisiana
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services
- As a potential member, to receive information about the basic features of the Healthy Louisiana program; which populations may or may not enroll in the program and Aetna Better Health of Louisiana's responsibilities for coordination of care in a timely manner in order to make an informed choice
- To receive information on Aetna Better Health of Louisiana's services, to include, but not limited to:
  - Benefits covered;
  - Procedures for obtaining benefits, including any authorization requirements;
  - Any cost sharing requirements;
  - Service area;
  - Names, locations, telephone numbers of and non-English language spoken by current contracted providers, including at a minimum, primary care physicians, specialists, and hospitals;
  - Any restrictions on member's freedom of choice among network providers;
  - Providers not accepting new patients; and
  - Benefits not offered by Aetna Better Health of Louisiana but available to members and how to obtain those benefits, including how transportation is provided.

- To receive a complete description of disenrollment rights at least annually
- To receive notice of any significant changes in core benefits and services at least 30 days before the intended effective date of the change
- To receive information on grievance, appeal, and State Fair Hearing procedures
- To voice complaints, grievances, or appeals about Aetna Better Health of Louisiana of the care provided to members
- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
  - What constitutes an emergency medical condition, emergency services, and post- stabilization services;
  - That emergency services do not require prior authorization;
  - The process and procedures for obtaining emergency services;
  - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract;
  - Member's right to use any hospital or other setting for emergency care; and
  - Post-stabilization care services rules as detailed in 42 CFR §422.113(c).
- To receive Aetna Better Health of Louisiana's policy on referrals for specialty care and other benefits not provided by the member's PCP.
- To make recommendations about Aetna Better Health of Louisiana's member rights and responsibilities policy
- To have his/her privacy protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 Subparts A and E, to the extent that they are applicable.
- To exercise these rights without adversely affecting the way Aetna Better Health of Louisiana, its providers, or LDH treat the member.
- To obtain an advanced directive
- To refuse medical treatment and service and be made aware of the likely result of such refusal
- To utilize Urgent Care services
- To obtain a second opinion from a medical professional

Member Responsibilities

Aetna Better Health of Louisiana encourages members to be responsible for their own health care by becoming informed and active participants in their care. Aetna Better Health of Louisiana members, their families, or guardians are responsible for:

- Knowing the name of the assigned PCP and care manager
- Familiarizing themselves about their coverage and the rules they must follow to get care to the best of the member's ability

- Respecting the health care professionals providing service
- Contacting Aetna Better Health of Louisiana to obtain information or share any concerns, questions, or problems
- Accurately providing all necessary health related information needed by the professional staff providing care or letting the provider know the reasons the treatment cannot be followed, as soon as possible
- Following instructions and guidelines agreed upon with the health care professionals giving care and cooperating fully with providers in following mutually acceptable courses of treatment
- Understanding their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible, and letting their doctor know if they do not understand
- Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider
- Reporting on treatment progress, such as notifying their health care provider promptly if serious side effects and complications occur, and worsening of the condition arises
- Reporting changes like address, telephone number and assets, and other matters that could affect the member's eligibility to the office where the member applied for Medicaid services
- Protecting their member identification card and providing it each time they receive services
- Informing Aetna Better Health of Louisiana of the loss or theft of their ID card
- Disclosing other insurance they may have and applying for other benefits they may be eligible for
- Scheduling appointments during office hours, when possible
- Being present at scheduled appointments, arriving on time, and making any needed follow-up appointments
- Notifying the health care professionals in advance if it is necessary to cancel or reschedule an appointment
- Bringing immunization records to all appointments for children under eighteen (18) years of age
- Accessing preventive care services, living health lifestyles, and avoiding behaviors known to be detrimental to their health
- Following Aetna Better Health of Louisiana's grievance processes if they have a disagreement with a provider.
- To provide medical staff with a living will when one has been obtained by the member
- To track the member's financial responsibilities and copays owed to providers

For questions or concerns, please contact our Provider Experience Department at **1-855-242-0802**.

Member Rights Under Rehabilitation Act of 1973
Section 504 of the Rehabilitation Act of 1973 is a national law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to organizations that receive financial assistance from any federal department or agency, including hospitals, nursing homes, mental health centers, and human service programs.

Section 504 prohibits organizations from excluding or denying individuals with disabilities an equal opportunity to receive benefits and services. Qualified individuals with disabilities have the right to participate in, and have access to, program benefits and services.

Under this law, individuals with disabilities are defined as persons with a physical or mental impairment that substantially limits one or more major life activities. People who have a history of physical or mental impairment, or who are regarded as having a physical or mental impairment that substantially limits one or more major life activities, are also covered. Major life activities include caring for oneself, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning. Some examples of impairments that may substantially limit major life activities, even with the help of medication or aids/devices, are: Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug use, heart disease, and mental illness.

In addition to meeting the above definition, for purposes of receiving services, qualified individuals with disabilities are persons who meet normal and essential eligibility requirements.

Providers treating members may not, on the basis of disability:

- Deny qualified individuals the opportunity to participate in or benefit from federally funded programs, services, or other benefits
- Deny access to programs, services, benefits, or opportunities to participate as a result of physical barriers

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

The EPSDT Program consists of two mutually supportive, operational components: **(1) assuring the availability and accessibility of required health care resources; and (2) helping members and their guardians effectively use these resources.** These components enable Medicaid agencies to manage a comprehensive health program of prevention and treatment, to seek out eligible members and inform them of the benefits of prevention and the health services and assistance available and to help them and their families use health resources, including their own talents and knowledge, effectively and efficiently. It also enables them to assess the patient's health needs through initial and periodic examinations and evaluations, and to see that the health problems found are diagnosed and treated early before they become more complex and their treatment more costly. (Adapted from CMS website at **www.cms.gov/MedicaidEarlyPeriodicScrn/**).

Periodicity Schedule

The American Academy of Pediatrics publishes periodicity schedules that identify minimum guidelines for EPSDT screenings. You can view updated schedules on their website at **http://brightfutures.aap.org/clinical_practice.html**. ABHLA adheres to the schedule with the following two exceptions, which are aligned with the Louisiana Medicaid program:

- The Louisiana Medicaid EPSDT screening guidelines and policies apply to individuals under 21 years of age; and
- The Louisiana Medicaid schedule has stricter requirements for lead assessment and blood lead screening. See **lead screening**.

Identifying Barriers to Care

Understanding barriers to care is essential to helping members receive appropriate care, including regular preventive services. We find that although most members and caregivers understand the importance of preventive care, many confront seemingly insurmountable barriers to readily comply with preventive care guidelines. A recent study by the U.S. Department of Health and Human Services found that fewer than 50 percent of children in the study sample received any documented EPSDT services. To address this, Aetna Better Health of Louisiana trains its Member Services and Care Management Staff to identify potential obstacles to care during communications with members, their family/caregivers, Primary Care Providers (PCPs) and other relevant entities and works to maintain access to services.

Examples of barriers to preventive care that we have encountered include:

- Cultural or linguistic issues
- Lack of perceived need if the member is not sick
- Lack of understanding of the benefits of preventive services
- Competing health-related issues or other family/work priorities
- Lack of transportation
- Scheduling difficulties and other access issues

We work with providers to routinely link members with services designed to enhance access to preventive services, including:

- Facilitating interpreter services
- Locating a provider who speaks a particular language

- Arranging transportation to medical appointments
- Linking members with other needed community-based support services

Aetna Better Health of Louisiana closely monitors EPSDT metrics throughout the year to identify trends and potential opportunities for improvement. Aetna Better Health of Louisiana also notifies members annually of their eligibility for EPSDT services and encourages the use of the services.

Educating Members about EPSDT Services

Aetna Better Health of Louisiana informs members about the availability and importance of EPSDT services, including information regarding wellness promotion programs that Aetna Better Health of Louisiana offers. The information process includes:

- Member Handbook & Evidence of Coverage
- Member newsletters and bulletins
- Aetna Better Health of Louisiana's website
- Educational flyers
- Reminder postcards
- Care plan interventions for high-risk members enrolled in care management
- Member Services care gap education

Provider Responsibilities in Providing EPSDT Services

Participating providers will be contractually required to do the following in providing EPSDT services:

- Provide EPSDT screenings and immunizations to children aged birth to twenty-one (21) years of age in accordance with Louisiana's periodicity schedule, including federal and State laws standards and national guidelines (i.e., **American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care**) and as federally mandated.
  - Avoid delays in pediatric screenings and services by taking advantage of opportunities (for instance, provide an immunization, or screening during a visit for a mild acute illness or injury or during a sibling's visit).
  - Fully document all elements of each EPSDT assessment, including anticipatory guidance and follow-up activities on the state-required standard encounter documentation form and verify that the record is completed and readable.
  - Comply with Aetna Better Health of Louisiana's Minimum Medical Record Standards for Quality Management, EPSDT Guidelines and other requirements under the law.
  - Cooperate with Aetna Better Health of Louisiana's periodic reviews of EPSDT services, which will include chart reviews to assess compliance with standards.
  - Report members' EPSDT visits by recording the applicable Current Procedural Terminology (CPT) preventive codes on the required claim submission form
  - Contact members or their parents/guardians after a missed EPSDT appointment so that it can be rescheduled.
  - Have systems in place to document and track referrals including those resulting from an EPSDT visit. The system should document the date of the referral, date of the appointment and date information is received documenting that the appointment occurred.
  - Comply with "pay and chase" mandate for Preventive Pediatric Care, which includes EPSDT services, for children.

Aetna Better Health of Louisiana requires participating providers to make the following recommended and covered services available to EPSDT-eligible children at the ages recommended on the state Medicaid regulators' periodicity schedule:

- Immunizations, education, and screening services, provided at recommended ages in the child's development, including all of the following:
  - Comprehensive health and developmental history (including assessment of both physical and mental health development)
  - Comprehensive unclothed physical exam
  - Appropriate immunizations (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines) and, where appropriate, in compliance with the **Vaccines for Children (VFC)** program.

- Laboratory tests (including appropriate neonatal, iron deficiency anemia, and blood lead screening)
- Health education/anticipatory guidance - Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and dental exams provide the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention
- Vision services, including periodic screening and treatment for defects in vision, including eyeglasses
- Dental services, including oral screening, periodic direct referrals for dental examinations (according to the state periodicity schedule), relief of pain and infections, restoration of teeth, and maintenance of dental health
- Hearing services, including, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids
- Lead toxicity screening, consisting of the following components:
    - a risk assessment questionnaire at every well child visit
    - a blood test to screen all children at ages 12 months and 24 months, or at any time from ages 36 – 72 months, if not previously screened
    - a venous blood sample to confirm results when a finger stick sample indicates blood lead levels ≥15ug/dl. Medical providers MUST report a lead case to the Office of Public Health's Childhood Lead Poisoning Prevention Program by fax within 24 working hours. A lead case is indicated by a blood lead test result of >15ug/dl (micrograms per deciliter). Mail the original **lead case reporting form** within five business days.
- Other necessary health care to correct or ameliorate physical and mental illnesses and conditions discovered by the screening process

- Diagnostic services, including referrals for further evaluation whenever such a need is discovered during a screening examination
- Treatment or other measures to correct or improve defects and physical and mental illnesses or conditions discovered by the screening services

For questions or concerns, please contact our Provider Experience Department at **1-855-242-0802**.

Reimbursement

The EPSDT component services below are included in reimbursement of the preventive medicine Evaluation and Management (E&M) visit unless appended with Modifier 25 (Sick visit with Well-child visit), which indicates a significant, separately identifiable E&M service by the same provider on the same day of a procedure or other service:

- Comprehensive health history
- Comprehensive unclothed physical examination
- Health education
- Nutritional assessment
- Dental screening

Periodic Screening

ABHLA requires providers to inform Members about and to make the following recommended and covered services available to all EPSDT-eligible enrollees at the recommended age per the **Periodicity Schedule**. 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 aged two through six years of age must be at least six months apart.

Preventive Medical Screening

Preventive Medical Screenings must include the following:

- Comprehensive health and developmental history, including:
    - Assessment of physical health and development
    - Assessment of mental health and development
- Comprehensive unclothed physical exam or assessment

- Appropriate immunizations according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines and health history (unless medically contraindicated or parents/guardians refuse at the time)
- Laboratory tests (including age-appropriate screenings for newborns, iron deficiency anemia, blood lead* levels, dyslipidemia, and sexually transmitted infections); and
- Health education (including anticipatory guidance)

* 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.

EPSDT services must 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.

Neonatal/Newborn Screening
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).

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.

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.

Laboratory Screening
Iron deficiency anemia and blood lead testing when required are included in the medical screening fee and must not be billed separately.

Effective May 1, 2024, Proprietary Laboratory Analyses codes 0202U, 0223U, 0224U, 0225U, 0226U, 0240U, and 0241U are only covered in a facility, observation, and/or inpatient setting.

Blood Lead Screening
ABHLA must ensure that 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 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 ≥5 μg/dl (micrograms per deciliter).

Providers must 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.

Effective for dates of service on and after 11/1/2021, claims for EPSDT preventive screening visits appended with modifier 'TD' will be denied.

The physician, advanced practice registered nurse, or physician assistant listed as the rendering provider must be present and involved during the preventive screening visit. Any care provided by a registered nurse (RN) in the office or outpatient setting is subject to Medicaid's "Incident to" policy.

Interperiodic Screening

Interperiodic screenings may be performed if medically necessary. The parent/guardian or any medical provider or qualified health, developmental, or education professional who 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 medical 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.

Developmental Screening

ABHLA covers developmental and autism screenings administered during EPSDT preventive visits in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule. ABHLA also covers 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.

ABHLA covers only the use of age-appropriate, caregiver-completed, and validated screening tools as recommended by the AAP:

- Ages and Stages Questionnaire (ASQ) - 2 months to age 51
- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
- Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months
- Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2
- Brigance Screens-II - Birth to 90 months
- Child Development Inventory (CDI) - 18 months to age 6
- Infant Development Inventory - Birth to 18 months
- Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
- Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)

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 (96110). 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 (2) units of procedure code 96110.

Perinatal Depression Screenings
ABHLA covers perinatal depression screening administered to the enrollee's caregiver in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule. Screening can be administered from birth to 1 year during an EPSDT preventive visit, an interperiodic visit, or an E&M office visit. This service is a recommended, but not required, component of well-child care.

- 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.

ABHLA reimburses perinatal depression screening under the child enrollee's Medicaid coverage. When two (2) or more children under age 1 present to care on the same day (e.g., twins or other siblings who are both under age 1), the provider must submit the claim for 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

Diagnostic Services and Treatment Services
ABHLA must ensure that the enrollee receives the diagnostic services and all treatment services required as a result of diagnostic services.

PCP Notification
On at least a quarterly basis Aetna Better Health of Louisiana will provide all PCPs with a list of members who have not had an encounter and who have not complied with the EPSDT periodicity and immunization schedules for children.

Direct-Access Immunizations
Member may receive influenza and pneumococcal vaccines from any network provider without a referral, and there is no cost to the member if it is the only service provided at that visit.

EPSDT Comprehensive Dental Benefit
Per LDH **Informational Bulletin 25-6**: Federal law, 42 CFR Part 441 Subpart B, mandates EPSDT-eligible beneficiaries are eligible to receive all medically necessary health care, screening, diagnostic services, treatment, and other measures to correct or improve physical or mental conditions (section 1905(r) of the Social Security Act). Unless prohibited or excluded, services may include those not otherwise covered by the Louisiana Medicaid State Plan or explicitly described in Dental Benefit Program Manager (DBPM) contracts. These regulations include dental care, at the earliest age necessary, needed for:

- relief of pain
- infections
- restoration of teeth
- maintenance of dental health
- emergency care
- preventative care, and
- therapeutic care.

Aetna Better Health of Louisiana (ABHLA) reimburses the administration fee for vaccines provided by the VFC Program for eligible members (birth through 18 years of age), except where provider, state, federal, CMS, or other requirements or contracts specify otherwise.

ABHLA reimburses VFC vaccine administration fees to only those providers who are registered with the Centers for Disease Control (CDC) as VFC Providers. For additional information about enrolling as a VFC Provider, visit LDH Louisiana Vaccines for Children.

VFC Providers must use vaccines available without charge under the Vaccine for Children (VFC) Program for Medicaid children eighteen (18) years old and younger. Immunizations shall be given in conjunction with EPSDT/Well Child visits or when other appropriate opportunities exist.

Reimbursement

ABHLA reimburses per the Louisiana Medicaid immunization fee schedule, then per the contract and, if necessary, a negotiated rate up to the maximum fee limits set by the CDC and applicable modifiers.

ABHLA does not reimburse VFC Providers for vaccine serum, as it is provided at no cost by the VFC Program.

Claims submitted for vaccination(s) must include serum code(s) for compliance with regulatory and HEDIS® reporting requirements to indicate that members are receiving required immunization(s). Claims submitted without applicable serum, administration, and modifier codes may be rejected and/or denied.

Vaccine administration is reimbursed separately from office visits or well-child exams. ABHLA does not reimburse an office visit when vaccine administration is the only service performed.

Non-VFC Vaccines

ABHLA reimburses providers for the administration and serum for members not eligible for VFC, or for vaccines not provided by VFC. Reimbursement is based on the fee schedule, then according to the contract and, if necessary, according to a negotiated rate.

Shortages

Should a documented supply shortage occur within the Louisiana VFC program, ABHLA will reimburse providers for serum(s) according to the fee schedule, then according to the contract and, if necessary, according to a negotiated rate. ABHLA is alerted by LDH and through the Louisiana Health Alert Network when vaccine shortages occur and will communicate this information to the network as appropriate.

Members with Special Needs

Adults with special needs include our members with complex and chronic medical conditions requiring specialized health care services. This includes persons with disabilities due to physical illnesses or conditions, behavioral health conditions, substance use disorders, and developmental disabilities. Members may be identified as having special needs because they are homeless. Children with special health care needs are those members who have or are at an increased risk for a chronic physical, developmental, behavioral, or emotional condition, and who require health and related services of a type or amount beyond that generally required by children.

Aetna Better Health of Louisiana developed methods for:

- Promoting well-child care to children with special needs, who may be cared for by multiple subspecialists
- Health promotion and disease prevention for adults and children identified as having special needs
- Coordination and approval for specialty care when required
- Diagnostic and intervention strategies to address the specific special needs of these members
- Coordination and approval of home therapies and home care services when indicated
- Care management for adults with special needs to address self-care education to reduce long-term complications and to coordinate care so that long-term complications may be treated as necessary
- Care management systems to assure that children with serious, chronic, and rare disorders receive appropriate diagnostic work ups on a timely basis
- Access to specialty centers inside and outside of Louisiana for diagnosis and treatment of rare disorders

The Initial Health Screen (HIS) for new members will assist us in identifying those with special needs. We will also review hospital and pharmacy utilization data. Additionally, we rely on you, our network providers, to identify members who are at risk of or have special needs and those who are at risk for nursing home level of care. Once identified, we will follow-up with a Comprehensive Needs Assessment for each of these members performed by case managers.

Aetna Better Health of Louisiana has 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.

Aetna Better Health of Louisiana will develop care plans that address the member's service requirements with respect to specialist physician care, durable medical equipment, medical supplies, home health services, social services, transportation, etc. Our care management and utilization management teams collaborate closely so that all required services are furnished on a timely basis. We facilitate communication among providers, whether they are in or out of our network.

Outreach and enrollment staff is trained to work with members with special needs, to be knowledgeable about their care needs and concerns. Our staff uses interpreters when necessary to communicate with members who prefer not to or are unable to communicate in English and use the LA Relay system and American Sign Language interpreters, if necessary.

If a new member upon enrollment or a member upon diagnosis requires very complex, highly specialized health care services, the member may receive care from a contracted specialist or a contracted specialty care center with expertise in treating the life-threatening disease or specialized condition. The specialist or specialty care center will be responsible for providing and coordinating the member's primary and specialty care. The specialist or specialty care center, acting as both primary and specialty care provider, will be permitted to treat the member without a referral from the member's Primary Care Provider (PCP) and may authorize such referrals, procedures, tests, and other medical services. If approval is obtained to receive services from a non-network provider, the care will be provided at no cost to the member. If our network does not have a provider or center with the expertise the member requires, we will authorize care out of network.

After-hours protocol for members with special needs is addressed during initial provider trainings, in our Provider Manual. Providers must be aware that non-urgent condition for an otherwise healthy member may indicate an urgent care need for a member with special needs. We expect our contracted providers to have systems for members with special needs to reach a provider outside of regular office hours. Our Aetna Better Health of Louisiana Nurse Line is available 24 hours a day, 7 days a week for members with an urgent or crisis situation.

Aetna Better Health of Louisiana require our contacted providers to use the most current diagnosis and treatment protocols and standards established by the medical community in conjunction with the Louisiana Department of Health (LDH). During initial provider orientations, we will highlight and reinforce the importance of using the most current diagnosis and treatment protocols.

Provider Monitoring

The methods we utilize to monitor our providers and members compliance/success in obtaining the appropriate care associated with EPSDT include a multi-pronged approach to maximize our quality results and care of this specific member population. The methods include, but are not limited to:

- Analysis and evaluation of provider utilization
    - EPSDT Audit and other provider office visits
    - EPSDT Compliance Report
- Tracking and trending provider data
    - Evaluation of performance measures and outcome data including Healthcare Effectiveness Data and Information Set (HEDIS®) and Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) results (monitoring results on a monthly basis)
- Review and tracking of member grievances and appeals and provider complaints to identify trends
    - Peer review of quality, safety, utilization, and risk management referrals
    - Recredentialing review activities
    - Review of gaps in care reports and analysis of data from PCP profiles and performance reports
    - Review of sentinel events
- Monitoring network capacity and availability and accessibility to care delivery systems, recredentialing review activities

Our Provider Experience Department educates providers about EPSDT program requirements and monitors the adequacy of our EPSDT network. Provider Experience Staff may take referrals from a provider to have a member outreached by care management staff, especially if the provider has been unable to reach the member to schedule an appointment for EPSDT-related services. Providers Services Staff may also take referrals from providers who identify problems through EPSDT exams.

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Tools to Identify and Track At-Risk Members

Aetna Better Health of Louisiana uses data-driven tools to provide early detection of members who are at risk of becoming high cost, who have actionable gaps or errors in care and who may benefit from Care Management. These tools have two main components. The first is our predictive modeling tool known as the CORE model, or Consolidated Outreach and Risk Evaluation, which uses predictive modeling based on claims data, pharmacy data, and diagnoses along with predictive modeling that indicates each member's risk of ED utilization and inpatient admission over the next twelve (12) months. We supplement this information with data collected from Health Risk Assessments. We track member information in a web-based care management tracking application. These tools, described below, enable us to work closely with providers, members and their families or caregivers to help improve clinical outcomes and enhance the quality of members' lives.

Predictive Modeling

Aetna Better Health of Louisiana's predictive modeling software identifies and stratifies members who are eligible for our care management programs. It sorts, analyzes, and interprets historical claims, pharmacy, clinical and demographic data to identify gaps in care and to make predictions about future health risks for each member. The application funnels information from these various sources into a member profile that allows our Case Managers to access a concise twelve (12) month summary of activity. This data then links to our customized care management tracking application.

Once analyzed, our predictive modeling software ranks members and prepares a monthly "target" report of the members most likely to benefit from care management services. In addition to the scoring methodology, predictive modeling also looks at certain "triggers" to alert Case Managers to potential risk factors, including:

- Members with new hospital authorizations (currently inpatient) or authorizations for certain scheduled services (i.e., home health or selected surgical procedures)
- Call tracking from Aetna Better Health of Louisiana's Member Services Department

Initial Health Screen (IHS)

Aetna Better Health of Louisiana also assesses members through the Initial Health Screen (His) tool. Aetna Better Health of Louisiana staff members go over the IHS with the member or caregiver during a telephone call made to each member to welcome them to the health plan. The IHS gathers:

- Member contact information
- Primary Care Provider (PCP) or medical home information
- Member's health history and self-rated assessment of health
- Frequency of ER use
- Medication usage

CM Business Application Systems

Our care management business application system stores and retrieves member data, claims data, pharmacy data, and history of member interventions and collaboration. It houses a comprehensive assessment, condition-specific questionnaires and care plans and allows care management staff to set tasks and reminders to complete actions specific to each member. It provides a forum for clear and concise documentation of communication with providers, members, and caregivers. It retains history of events for use of the information in future cases. The system interfaces with our predictive modeling software, the inpatient census tool and allows documents to be linked to the case. It also provides multiple queries and reports that measure anything from staff productivity and staff interventions to coordination and collaboration and outcomes in care management.

Medical Necessity

Medical necessity is defined as a service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the provider and in accordance with Aetna Better Health of Louisiana's guidelines for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the member's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.

Any such services must be clinically appropriate, individualized, specific, and consistent with the symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-Demonstration approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

Determination of medical necessity for covered care and services, whether made on a prior authorization, concurrent review, retrospective review, or on an exception basis, must be documented in writing. The determination is based on medical information provided by the member, the member's family/caregiver, and the PCP, as well as any other providers, programs, agencies that have evaluated the member. Medical necessity determinations must be made by qualified and trained health care providers.

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Concurrent Review Overview

Aetna Better Health of Louisiana conducts concurrent utilization review on each member admitted to an inpatient facility. Concurrent review activities include both admission certification and continued stay review. The review of the member's medical record assesses medical necessity for the admission, and appropriateness of the level of care, using the Milliman Care Guidelines®. Admission certification is conducted within one business day of receiving notification.

Continued stay reviews are conducted before the expiration of the assigned length of stay. Providers will be notified of approval or denial of length of stay. Our nurses conduct these reviews. The nurses work with the medical directors in reviewing medical record documentation for hospitalized members. Our medical directors make rounds on site as necessary.

All inpatient admissions require notification to Aetna Better Health of Louisiana within one business day of the admission. All planned (non- emergency) inpatient admissions require prior authorization.

Milliman Care Guidelines

Aetna Better Health of Louisiana uses the Milliman Care Guidelines® to verify consistency in hospital–based utilization practices. The guidelines span the continuum of member care and describe best practices for treating common conditions. The Milliman Care Guidelines® are updated regularly as each new version is published. A copy of individual guidelines pertaining to any covered service is available for review upon request.

Discharge Planning Coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the member and for involving the member and family in implementing the plan.

Our Concurrent Review Nurse (CRN) works with the hospital discharge team and attending physicians to verify that cost-effective and quality services are provided at the appropriate level of care. This may include, but is not limited to:

- Assuring early discharge planning
- Facilitating or attending discharge planning meetings for members with complex and multiple discharge needs.
- Providing hospital staff and attending physician with names of network providers (i.e., home health agencies, Durable Medical Equipment (DME)/medical supply companies, other outpatient providers).
- Informing hospital staff and attending physician of covered benefits as indicated.

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Primary care providers (PCP) or treating providers are responsible for initiating and coordinating a members request for authorization. However, specialists, PCPs and other providers may need to contact the Prior Authorization Department directly to obtain or confirm a prior authorization.

The requesting provider is responsible for complying with Aetna Better Health of Louisiana's prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims. Aetna Better Health of Louisiana will not prohibit or otherwise restrict providers, acting within the lawful scope of their practice, from advising, or advocating on behalf of, an individual who is a patient and member of Aetna Better Health of Louisiana about the patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Emergency Services

Emergency medical services are permitted to be delivered in or out of network without obtaining prior authorization if the member was admitted for the treatment of an emergency medical condition. Aetna Better Health of Louisiana will not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Payment will not be withheld from providers in or out of network. However, all inpatient admissions require notification within one (1) business day of the admission. The notification will be documented by the Prior Authorization Department or concurrent review clinician.

Post-stabilization Services

Aetna Better Health of Louisiana will cover post-stabilization services under the following circumstances without prior authorization, whether or not the services are provided by an Aetna Better Health of Louisiana network provider:

- The provider requested prior approval for the post-stabilization services, but Aetna Better Health of Louisiana did not respond within one hour of the request
- The provider could not reach Aetna Better Health of Louisiana to request prior approval for the services and has proof of due diligence in attempting to do so
- The Aetna Better Health of Louisiana representative and the treating provider could not reach an agreement concerning the member's care, and an Aetna Better Health of Louisiana medical director was not available for consultation
    - Note: In such cases, the treating provider will be allowed an opportunity to consult with an Aetna Better Health of Louisiana medical director; therefore, the treating provider may continue with the member's care until a medical director is reached or any of the following criteria are met;
    - An Aetna Better Health of Louisiana provider with privileges at the treating hospital assumes responsibility for the member's care;
    - An Aetna Better Health of Louisiana provider assumes responsibility for the member's care through transfer;
    - Aetna Better Health of Louisiana and the treating provider reach an agreement concerning the member's care; or
    - The member is discharged.

Services Requiring Prior Authorization

Our Secure Web Portal located on our website, lists the services that require prior authorization, consistent with Aetna Better Health of Louisiana's policies and governing regulations. The list is updated at least annually and updated periodically as appropriate.

Unauthorized services will not be reimbursed, and authorization is not a guarantee of payment. All out of network services must be authorized.

Exceptions to Prior Authorizations

- Access to family planning services
- Well-woman services by an in-network provider
- Emergency medical services

Provider Requirements

Generally, a member's PCP, or treating provider is responsible for initiating and coordinating a request for authorization.

A prior authorization request must include the following:

- Current, applicable codes may include:
  - Current Procedural Terminology (CPT)
  - International Classification of Diseases, ICD-10
  - Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) codes
  - National Drug Code (NDC)
- Name, date of birth, sex, and identification number of the member
- Primary care provider or treating provider
- Name, address, phone and fax number and signature, if applicable, of the referring or provider
- Name, address, phone, and fax number of the consulting provider
- Problem/diagnosis, including the ICD-10 code
- Reason for the referral
- Presentation of supporting objective clinical information, such as clinical notes, laboratory and imaging studies, and treatment dates, as applicable for the request

All clinical information must be submitted with the original request. Clinical information is due by 3 PM if received after 3 PM it will be considered as received on the next business day.

We will take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe. Providers who do not provide requested medical information for purposes of making medical necessity determinations, for a particular item or service, will not be entitled to payment for the provision of such item or service. *"We reserve the right to deny coverage of services should a provider fail to, or refuse to, respond to our request(s) for medical record information. "*

How to request Prior Authorizations

A prior authorization request may be submitted by:

- Submitting the request through the 24/7 Secure Availity Provider Web Portal located on the Aetna Better Health of Louisiana 's website at **AetnaBetterHealth.com/Louisiana/Providers**, or
- Fax the request form to **1-844-227-9205** (form is available on our website). Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing, or
- Through our toll-free number

A prior authorization request form can be found at https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/louisiana/pdf/PA%20request%20form_LA.pdf, or authorizations can be submitted through the Availity portal. Using this form can help expedite the authorization process by filling in the required information, attaching appropriate clinical information and faxing to the authorization department.

An authorization request may also be submitted through the Availity Web Portal. Clinical information can be attached to the authorization request. To check the status of a prior authorization you submitted or to confirm that we received the request, please visit the Availity Web Portal, or call us at **1-855-242-0802**. The portal will allow you to check status, view history, and email a Case Manager for further clarification if needed.

If response for non-emergency prior authorization is not received within 15 days, please contact us at **1-855-242-0802**.

Treating Provider Becomes Unavailable
Aetna Better Health of Louisiana will provide notice to a member, or the parent or legal guardian and to the involved state agency as appropriate, notice regarding who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice will be provided within seven (7) calendar days from the date we become aware of such, if it is prior to the change occurring.

Medical Necessity Criteria
To support prior authorization decisions, Aetna Better Health of Louisiana uses nationally recognized, and community developed, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Prior authorization staff members that make medical necessity determinations are trained on the criteria and the criteria is established and reviewed according to Aetna Better Health of Louisiana policies and procedures.

Clinical medical necessity determinations are based only on the appropriateness of care and service and the existence of coverage. Aetna Better Health of Louisiana does not specifically reward practitioners or other individuals for issuing denials of coverage or care or provide financial incentives of any kind to individuals to encourage decisions that result in underutilization.

For prior authorization of elective inpatient and outpatient medical services, Aetna Better Health of Louisiana uses the following medical review criteria. Criteria sets are reviewed annually for appropriateness to the Aetna Better Health of Louisiana's population needs and updated as applicable when nationally or community-based clinical practice guidelines are updated. The annual review process involves appropriate providers in developing, adopting, or reviewing criteria. The criteria are consistently applied, consider the needs of the members, and allow for consultations with requesting providers when appropriate. Providers may obtain a copy of the utilization criteria upon request by contacting an Aetna Better Health of Louisiana provider experience representative. These are to be consulted in the order listed:

- Criteria required by applicable State or federal regulatory agency
- Applicable Milliman Care Guidelines (MCG) as the primary decision support for most medical diagnoses and conditions
- Aetna Better Health of Louisiana Clinical Policy Bulletins (CPBs)
- Aetna Better Health of Louisiana Policy Council Review

If MCG state "current role remains uncertain" for the requested service, the next criteria in the hierarchy, Aetna Better Health of Louisiana CPBs, should be consulted and utilized.

For prior authorization of outpatient and inpatient services, Aetna Better Health of Louisiana uses:

- Criteria required by applicable State or federal regulatory agency
- LOCUS/CASII Guidelines/American Society of Addiction Medicine (ASAM)
- Aetna Better Health of Louisiana Clinical Policy Bulletins (CPB's)
- Aetna Better Health of Louisiana Clinical Policy Council Review

Medical, dental, and behavioral health management criteria and practice guidelines are disseminated to all affected providers upon request and, upon request, to members and potential members.

Timeliness of Decisions and Notifications to Providers, and Members
Aetna Better Health of Louisiana makes prior authorization decisions and notifies providers and applicable members in a timely manner. Unless otherwise required by the Louisiana Department of Health (LDH), Aetna Better Health of Louisiana adheres to the following decision/notification time standards. Notice will be provided as expeditiously as the member's health condition requires, but in a timeframe not to exceed 14 calendar days following receipt of the request for service, in accordance with 42 C.F.R. 438.210)d)1. Aetna Better Health of Louisiana ensures the availability of

appropriate staff between the hours of 7 AM and 7 PM, seven days a week, to respond to authorization requests within the established time frames. Departments that handle pre-prior authorizations must meet the timeliness standards appropriate to the services required.

Decision/Notification Requirements

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent pre-service approval	72 hours from receipt of request	Practitioner/Provider	Oral and Electronic/Written
Urgent pre-service denial	72 hours from receipt of request	Practitioner/Provider Member	Oral and Electronic/Written
Non-urgent pre-service approval	80% of standard service authorizations within two (2) business days of obtaining appropriate medical information, inpatient elective authorizations within two (2) calendar days of obtaining appropriate medical information. But no later than 14 calendar days from receipt of the request. Documented confirmation within two (2) business days of making the initial certification	Practitioner/Provider	Oral and Electronic/Written
Non-urgent pre-service denial	80% of standard service authorizations within two (2) business days of obtaining appropriate medical information, inpatient elective authorizations within two (2) calendar days of obtaining appropriate medical information. But no later than 14 calendar days from receipt of the request. Documented confirmation within two (2) business days of making the initial certification	Practitioner/Provider Member	Oral and Electronic/Written
Non-urgent CPST and PSR pre-service approval	Five (5) calendar days from obtaining appropriate documentation. But no later than 14 calendar days from receipt of the request. Documented confirmation within two (2) business days of making the initial certification	Practitioner/Provider	Oral and Electronic/Written
Non-urgent CPST and PSR pre-service denial	Five (5) calendar days from obtaining appropriate documentation. But no later than 14 calendar days from receipt of the request. Documented confirmation within two (2) business days of making the initial certification	Practitioner/Provider Member	Oral and Electronic/Written
Urgent concurrent approval	95% within one (1) business day and ninety-nine point five percent (99.5%) within two (2) business days of obtaining appropriate medical information	Practitioner/Provider	Oral and Electronic/Written
Urgent concurrent denial	Notify provider verbally within one (1) business day and provide documented confirmation within two (2) business days of making the initial certification	Practitioner/Provider	Oral and Electronic/Written

Decision	Decision/notification timeframe	Notification to	Notification method
Crisis response service pre-service approval	One (1) calendar day from obtaining appropriate documentation. But no later than 14 calendar days from receipt of the request. Documented confirmation within two (2) business days of making the initial certification	Practitioner/Provider	Oral and Electronic/Written
Crisis response service pre-service denial	One (1) calendar day from obtaining appropriate documentation. But no later than 14 calendar days from receipt of the request. Documented confirmation within two (2) business days of making the initial certification	Practitioner/Provider Member	Oral and Electronic/Written
Post-service approval	30 calendar days of obtaining the results of appropriate medical information but no later than 365 days from the date of service	Practitioner/Provider	Oral or Electronic/Written
Post-service denial	30 calendar days as above	Practitioner/Provider Member	Electronic/Written
Termination, Suspension Reduction of Prior Authorization	At least 10 calendar days before the date of the action	Practitioner/Provider Member	Electronic/Written

Peer-to-Peer Reviews

You may ask for a copy of the Aetna Better Health of Louisiana benefit guidelines or clinical criteria that were used to make the denial decision by emailing: CriteriaRequest@aetna.com. If the treating doctor would like to discuss this case with one of our doctors, he or she may call Aetna Better Health of Louisiana at 1-855-242-0802 and request to speak with a Medical Director.

For medical necessity denials, the treating doctor may request a Peer-to-Peer Review. To request a Peer-to-Peer Review, please call **1-855-242-0802**, Press *, Say "Authorization", say "Something Else". A Prior Authorization Representative will answer. Ask to be transferred to schedule a "Peer to Peer Review."

Administrative Denial

All denials of service requests require a medical director review with the exception of administrative denials. Administrative denials are decisions that result from coverage requests for services that are not covered based on a contractual or benefit exclusion, breach of contract, benefit limitation or exhaustion and do not require a clinician to interpret the contractual limitation or apply clinical judgment to the limitation. Service code requests that fall under EPSDT are excluded from administrative denials.

Examples of administrative denials include:

- The individual is not a member at the time the service or supply is provided
- A limited benefit that is exhausted
- An excluded benefit/code
- Failure to obtain a prior authorization
- Breach of Contract, (e.g., when Aetna Better Health's contract requires notification of an admission within a specified timeframe and no notification is received)

Appeal Rights for an Administrative Denial

An appeal may be filed for the administrative denial. The appeal must specifically state the factual basis for the administrative appeal and the relief requested. You may attach any documents that you believe will assist us in reviewing your administrative appeal. Members or their designated representative can file a standard appeal with Aetna Better Health orally or in writing within sixty (60) calendar days from the postmark on the Aetna Better Health

Notice of Adverse benefit determination, also called the Notice of Action (NOA). We will review your request and let you know our decision within the standard appeal timeframes.

Appeals of administrative denials are limited to appeals for classification of the decision as administrative.

Prior Authorization Period of Validation

Prior authorization numbers are valid for the date of service authorized or for a period not to exceed sixty (60) days after the date of service authorized. The member must be enrolled and eligible on each date of service. Personal Care Services authorizations may be authorized for six (6) months at a time. If a member is designated as a "Chronic Needs" member, the certification period may be extended.

Out-of-Network Providers

When approving or denying a service from an out-of-network provider, Aetna Better Health of Louisiana will assign a prior authorization number, which refers to and documents the approval. Aetna Better Health of Louisiana sends written documentation of the approval or denial to the out-of-network provider within the time frames appropriate to the type of request. The notification letter includes a list of in-network provider options.

Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Aetna Better Health of Louisiana makes such decisions on a case-by-case basis in consultation with Aetna Better Health of Louisiana's medical director.

Notice of Action Requirements

Aetna Better Health of Louisiana provides the provider and the member with written notification (i.e., Notice of Action - NOA) of any decision to deny, reduce, suspend, or terminate a prior authorization request, limits, or to authorize a service in the amount, duration or scope that is less than requested or denies payment, in whole or part, for a service.

The notice will include:

- The action that Aetna Better Health of Louisiana has or intends to take
- The specific reason for the action, customized to the member circumstances, and in easily understandable language to the member
- A reference to the benefit provision, guideline, or protocol or other similar criterion on which the denial decision was based
- The name and contact information for the physician or dentist that reviewed and denied the service
- Notification that, upon request, the provider or member, if applicable, may obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based
- Notification that provider has the opportunity to discuss medical, dental, and behavioral healthcare UM denial decisions with a physician or other appropriate reviewer
- A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal
- An explanation of the appeals process, including the right to member representation (with the member's permission) and the timeframes for deciding appeals
- A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures
- The member's or provider (with written permission of the member) right to request a Medicaid State Fair Hearing and instructions about how to request a Medicaid State Fair Hearing
- A description of the expedited appeals process for urgent preservice or urgent concurrent denials
- The circumstances under which expedited resolution is available and how to request it
- The member's right to request continued benefits pending the resolution of the appeal or pending a Medicaid Fair Hearing, how to request continued benefits and the circumstances under which the member may be required to pay the costs of these benefits
- Translation service information
- The procedures for exercising the members rights
- If the member is a Chisholm member, potential denials are sent to LDH for prior approval before any denial notification is sent. Chisholm members that engage a support coordinator for case management services will also be included in decision notification.

Continuation of Benefits
Aetna Better Health of Louisiana will continue member's benefits during the appeal process if:

- The member or the provider files the appeal timely
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider (i.e., a network provider)
- The original period covered by the original authorization has not expired, unless inadequate notice was given to allow a member a timely appeal

Aetna Better Health of Louisiana will continue the member's benefits until one of the following occurs:

- The member withdraws the appeal.
- A State fair hearing office issues a hearing decision adverse to the member.
- The time period or service limits of a previously authorized service has been met

Prior Authorization and Coordination of Benefits
If other insurance is the primary payer before Aetna Better Health of Louisiana, prior authorization of a service is not required, unless it is known that the service provided is not covered by the primary payer. If the service is not covered by the primary payer, the provider must follow our prior authorization rules. If the service is not covered by the primary payer, the provider must follow ABHLA's prior authorization process. A request for a letter from the primary insurance is requested with the precertification request.

Self-Referrals
Aetna Better Health of Louisiana does not require referrals from Primary Care Providers (PCP) or treating providers. Members may self-refer access some services without an authorization from their PCP. These services include behavioral health care, vision care; Medicaid approved Alcohol and Drug Addiction facilities, adult dental care, family planning, and women's health care services. The member must obtain these self-referred services from Aetna Better Health of Louisiana's provider network, except in the case of family planning.

Member may access family planning services from any qualified provider. Members also have direct access to Women's Health Care Provider (WHCP) services. Members have the right to select their own women's health care provider, including nurse midwives participating in Aetna Better Health of Louisiana's network, and can obtain maternity and gynecological care without prior approval from a PCP.

We are committed to support the quality of healthcare you provide to Members each day. You can refer to this chapter for information about:

- Our Quality Assessment and Performance Improvement Program (QAPI)
- Clinical Practice and Preventive Health Guidelines
- Performance Measures
- Member Experience
- Performance Improvement Projects (PIPs)
- Patient Safety
- Continuity and Coordination of Medical Care
- Continuity of Coordination Between Medical Care and Behavioral Healthcare
- Medical Record Reviews
- Provider Monitoring and Treatment Record Reviews
- NCQA Accreditation
- Delegation

Our Quality Assessment and Improvement Program

Our Quality Assessment and Improvement Program (QAPI) is designed to facilitate a member's access to high-quality medical and/or behavioral healthcare, access to primary and specialty care, continuity, and coordination of care across settings, and culturally competent care, including quality and appropriateness of care furnished to Members with special health care needs.

With our QAPI, we measure and track key aspects of care and services, use data-driven monitoring to identify improvement opportunities, implement interventions and analyze data to determine overall intervention effectiveness in improving clinical care and Member outcomes.

Our strategies include performance projects, medical record audits, performance measures, Plan-Do-Study-Act cycles or continuous quality improvement activities, member and provider surveys, and activities that address healthcare disparities identified through data collection.

We strive for continuous improvement and innovation in meeting Members' healthcare needs and work with you to facilitate Members' access to high-quality healthcare in the right place, at the right time, and in the most effective and efficient manner possible. We obtain feedback from key stakeholders, Members and their families/caregivers, and providers, using feedback to make recommendations to improve performance.

We develop QAPI objectives each year as outlined in our annual QAPI Program Description, which documents the scope, structure and function of the QAPI. We also evaluate our success in achieving our annual QAPI goals each year and document the results in our Quality Assessment and Improvement Program Evaluation. The QAPI Program Description and our annual evaluation are available to you upon request. Please call the Member Services Department at **1-855-242-0802** and ask for the Quality Department to receive your free copy.

Quality Management Work Plan

Our program description includes a work plan that shows our progress on the Quality Improvement (QI) activities throughout the year. The work plan includes our objectives, timeframe for each activity's completion, the person who is responsible for each activity, and how we monitor previously identified issues. We evaluate and document ongoing monitoring activities quarterly and semi-annually for:

- Quality of clinical care

- Safety of clinical care
- Quality of service
- Members' experience

Quality Management and Utilization Management Committee

Your participation in the QAPI and feedback is important to us. We may ask you to become a member, or you may volunteer. The broad range of experience you bring will assist us in making decisions that may positively impact the Members you serve. The meetings occur quarterly, and sometimes more frequently if needed. We also provide a stipend to you for your participation. If you would like to become a member, please contact the Quality Department and we will send you an invite.

Quality improvement (QI) Activities

Provider contracts specify that providers cooperate with Aetna Better Health's quality improvement (QI) activities to:

- Improve the quality of care, services, and the Member experience, including the collection and evaluation of data
- Cooperate with QI activities, and provide clinical documentation, medical records and/or treatment records when requested by the Health Plan
- Allow the organization to collect and use performance measurement data
- Assist the organization in improving clinical and service measures
- Maintain the confidentiality of member information and records

We encourage you to freely communicate with our members about all treatment options, regardless of benefit coverage limitations.

Clinical Practice and Preventive Health Guidelines

Our physical health and behavioral health clinical practice guidelines, and our preventive health guidelines help ensure quality preventive care and care management is provided to our Members. We adopt and/or endorse evidence-based, disease-specific clinical practice and preventive guidelines that are either developed by credible medical sources and/or agencies or through regional partnerships. We periodically update our guidelines to include new information about treatments, medications and technology that reflects best practices. We review our clinical practice guidelines at least every two years, or whenever we learn about new medical evidence, to ensure consistency with accepted practice standards. We also make updated information available to you in a variety of ways, including through the Aetna Better Health website and our Provider newsletter. You can access our guidelines by clicking on the link **AetnaBetterHealth.com/Louisiana/providers/guidelines**.

Performance Measures

Aetna Better Health is required to report on specific performance measures as prescribed by the Louisiana Department of Health (LDH), the Office of Behavioral Health (OBH), and other State agencies. The State may change the performance yearly and sets the goal for improvement. Some of the performance measures are incentive based, and the Health Plan can receive a bonus for surpassing the goal or we may receive a financial penalty if we fail to meet State expectations.

It is important for you to ensure Members receive the tests and screenings they need to stay healthy. If you correctly code for the services provided, we can capture the work you've done administratively. This will lessen the burden of you receiving multiple faxed medical record requests during the annual HEDIS audit.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS measures are industry-standard indicators of the quality of care health plan Members receive. Aetna Better Health collects HEDIS data annually as well as on a monthly basis to monitor trends and identify opportunities to improve care for Members. HEDIS data is also evaluated against national and regional HEDIS benchmarks to assess the performance of our network. As you respond to our HEDIS-related requests, we are able to measure the quality of care you provide.

State Performance Metrics (Non-HEDIS)

Aetna Better Health is required to report on specific performance measures prescribed by the Louisiana Department of Health (LDH), the Office of Behavioral Health (OBH), and other State agencies as requested. These measures are drawn from: the CMS Children's Health Insurance Reauthorization Act (CHIPRA) and Adult Quality Measure Core Set, Agency for Healthcare Research and Quality (AHRQ), Preventive Quality Indicators (PQI) and also includes State of Louisiana specific measures and other nationally recognized measures.

Reporting/ Member Gaps in Care

You will receive a report listing the names of your members who are overdue for important health-related screenings and lab tests, or who may benefit from a discussion about medication usage. We recommend that you use this gap in care report as a guide for providing the necessary services needed by our members to keep them healthy. For more information about our gap in care reports or how you can improve your HEDIS and State performance rating scores, please call the Member Services Department at **1-855-242-0802** and ask for the Quality Department.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Assistance

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is the foundation for ensuring comprehensive and necessary medical care to all Medicaid recipients under the age of 21. Compliance with this program is essential for prompt identification of problems that, if left undiagnosed or untreated, could create greater disabilities or diminish one's likelihood of achieving future life goals. Aetna Better Health works to ensure that our members, especially those who are children, receive all services required to diagnose and treat potential and ongoing problems in a timely and culturally sensitive manner. Based on the EPSDT Periodicity Schedule, the Care Management and Quality Management teams provides outreach calls and mailings to remind Members about upcoming and past due wellness visits, offering assistance to address the barriers to attending appointments. Staff will also outreach to providers with Members who have missed wellness visits.

Performance Improvement Projects

Performance Improvement Projects (PIPs) engage the Health Plan, quality managers, providers, and members as a team with the common goal of improving patient care.[6] The Health Plan, in collaboration with the State, targets improvement for a specific activity. The next step is to identify barriers to care and then implement interventions to improve member outcomes. The interventions are tracked quarterly and analyzed annually. The current PIPs selected by LDH are:

- Improving Prenatal and Postpartum Care to Reduce the Risk of Preterm Birth
- Improving the Quality of Diagnosis, Management, and Care Coordination for Children and Adolescents with ADHD.

You will receive a notice by email, web, or mail if a PIP is changed, discontinued, or added. The Quality Management personnel may outreach to you to discuss these initiatives and/or you may contact them directly to learn more about these projects.

Member Experience

We implement different mechanisms to assess and improve member experience. We monitor the services provided and try to identify ways to improve how we do business and improve the quality of care being received.

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The Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a standardized survey that measures Members' experience with the services provided by you and us. This survey addresses child and/or their legal guardian and adult Members' experience with getting needed care, getting care quickly, how well you communicate, customer service, how decisions are made, health promotion and education completed, and how their coordination of care. They also rate their personal doctor, the specialist they see, the health care provided, as well as health plan's services. We may contact you with survey results to address any concerns.

Behavioral Health Surveys

The Behavioral Health survey is designed to assess member experiences and satisfaction with the behavioral health care received by Aetna Better Health child and adult Members. This survey addresses child and/or their legal guardian and adult Members' perceived improvement in their mental health, timeliness of receiving services or treatment, how the provider interacted with them, treatment, medication, and obtaining necessary information, and using Health Plan benefits. Results will be used to evaluate performance and identify gaps in service so that action can be taken to improve member experiences. You may be contacted with survey results to address any concerns.

Patient Safety

We address patient safety by:

- Distributing to Members information pertaining to optimal clinical practices and enhancing their ability to monitor the safety of their own care
- Improve continuity and coordination of care between providers or site of care to avoid miscommunication or delays in care that can lead to poor outcomes
- Review of Potential Quality of Care (PQOC) concerns expressed by Members, and taking action on complaints related to clinical safety[7]
- Monitoring adverse and unanticipated events, such as events resulting in death or serious physical or psychological injury occurring in inpatient and residential settings, and identifying trends that could indicate unsafe environments or practices in these contracted institutions. Providers are required to fill out the **LDH Adverse Incident Reporting Form** and fax it to Aetna Better Health at **1-860-262-9174**.
- Monitoring Health Care Acquired Conditions (HCACs), Other Provider Preventable Conditions (OPPCs), Serious Reportable Events (SREs) and Serious Reportable Adverse Events (SRAEs)
- All providers are required to inform Aetna Better Health of HACs, SREs, SRAEs and PPCs that occur when serving Members.
- Aetna Better Health will not compensate providers or permit providers to bill Members for services related to the occurrence of SREs, SRAEs and PPCs. Such nonpayment will not prevent patient access to healthcare services.

Continuity and Coordination of Medical Care

Aetna Better Health monitors and takes action to improve continuity and coordination of care across the health care network. Accessibility of Members to their primary care physician, specialist, and other necessary services is key to care coordination. The patient-centered medical home model is most strongly linked with clinical quality of care coordination, access, continuity, and communication.

Annually, we collect data on member movement between providers and across setting to identify opportunities for improvement through:

- Medical Record Review coordination of care audits
- Provider Continuity of Care Surveys
- Tracking 17 P medication administration for high-risk pregnancies

[7] HP NCQA 2018 QI 5

- Ted E. Bear® Weight and Nutrition Counseling Program for children and adolescent with obesity
- NICU Program with affiliated hospitals for premature birthed babies to assess the effectives of 17P medication administration
- Decreasing Emergency Room (ER) utilization rates through ER diversion.

Continuity and Coordination of Between Medical Care and Behavioral Healthcare

We also participate in behavioral healthcare clinical studies to look at how care is coordinated between the medical and behavioral healthcare provider. The key activities we focus on include:

- Provider Survey Continuity of Care between the Medical Care provider and the Behavioral Health clinician
- Treatment record reviews for behavioral health communication and collaboration with the member's primary care physician
- Care managers care coordination as part of their utilization management functions.
- Use of the complaints to identify concerns voiced by the member
- Antidepressant Medical Management (AMM) HEDIS® Measure for member treatment of depression
- Use a unified system or single case record for the member's medical and behavioral health management
- Fidelity monitoring of supportive services for children with serious behavioral health conditions who are at risk of out of home placement and those with serious mental illness
- Review of reports of our member's transition from inpatient psychiatric unit to skilled nursing level of care

Medical Record Reviews

We use medical record documentation standards to assess your record-keeping practices and we may audit these practices as part of ongoing network management.

You are required to cooperate with our chart audits. Chart audits are a part of our contractual obligations with regulatory agencies to monitor appropriateness of care and the quality of record-keeping.

Site visits initiated in response to complaints or quality concerns always include a medical record-keeping practice review. We will set up a time with you in advance to review the medical records. If you have any questions about our record review process, you may call the Member Services Department at 1-855-242-0802 and ask for the Quality Department.

Provider Monitoring and Treatment Record Reviews

We monitor specialized behavioral health care and substance use providers and facilities across all levels of care for adherence to State and Federal standards. Monitoring activities include, but are not limited to:

- On-site facility site visit, at a minimum of every three years and if a complaint is received
- Treatment record reviews (TRR) to assess your record keeping practices and adherence to clinical evidence-based practice guidelines
- Desktop administrative audits of programs, policies, training records, and credentialing files
- Member interviews of services received
- Corrective action plans issued, based on the degree of provider non-compliance with review criteria
- Follow-up activity to ensure action has been completed to prevent recurrence of the same issue

Confidentiality of member medical and/or behavioral health records

Aetna Better Health requires that providers comply with all applicable federal and state laws relating to the confidentiality of Member medical and behavioral health records, including but not limited to the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA).

Providers must:

- Maintain medical records in a space staffed by office personnel
- Maintain medical records in a locked office and/or a password-protected electronic medical record when staff is not present
- Prohibit unauthorized review and/or removal of medical records
- Maintain and adhere to policies and procedures regarding patient confidentiality and record retention

Aetna Better Health monitors providers' compliance with its confidentiality policies through clinical quality reviews and audits. Aetna Better Health requires providers, upon request, to provide Member medical information and medical and/or behavioral health records for the following purposes:

- Administering Aetna Better Health's benefit plans, such as claims payment, coordination of benefits, subrogation, enrollment eligibility verification, reinsurance, and audit activities
- Managing care, such as utilization management and quality improvement activities
- Carrying out Member satisfaction procedures described in our member handbook
- Participating in reporting on quality and utilization indicators, such as HEDIS
- Complying with the law

Note: A Member's consent/authorization to release medical records to Aetna Better Health for the purpose of an appeal and/or any quality activity is not necessary.

National Committee for Quality Assurance (NCQA)

Aetna Better Health must attain and retain health plan accreditation by NCQA. As such, we adhere to NCQA standards and guidelines to measure, analyze, and improve healthcare services. Aetna Better Health is contractually obligated to provide information to accreditation agencies, state, and federal governments about the quality of care that our members receive.

Delegation

Selected aspects of our members' services, claims, utilization management, pharmacy, disease management, and credentialing programs may be delegated to providers, service organizations, and vendors. We review these programs prior to delegation, and at least annually thereafter. We also perform ongoing monitoring, reviewing reports at least semi-annually. Please call the Member Services Department at **1-855-242-0802** and ask for the Quality Department if you have any questions or want to know more about delegation.

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Providers are required to comply with the Patient Self-Determination Act (PSDA), Physician Orders for Life Sustaining Treatment Act (POLST) and, the Louisiana Advance Directive rules (RS 40:1299.58.1 & RS 28:221), including all other State and federal laws regarding advance directives for adult members.

Advance Directives

Aetna Better Health of Louisiana defines advance directives as a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.

The advance directive must be prominently displayed in the adult member's medical record. Requirements include:

- Providing written information to adult members regarding each individual's rights under State law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections).
- Documenting in the member's medical record whether or not the adult member has been provided the information and whether an advance directive has been executed.
- Not discriminating against a member because of his or her decision to execute or not execute an advance directive and not making it a condition for the provision of care.
- Educating staff on issues related to advance directives as well as communicating the member's wishes to attending staff at hospitals or other facilities.
- Educate patients on Advance Directives (durable power of attorney and living wills).

For additional information about medical record requirements, please visit **Medical Records Requirements**.

Patient Self-Determination Act (PSDA)

The Patient Self-Determination Act (PSDA), passed in 1990 and instituted on December 1, 1991, encourages all people to make choices and decisions now about the types and extent of medical care they want to accept or refuse should they become unable to make those decisions due to illness.

The PSDA requires all health care agencies (hospitals, long-term care facilities, and home health agencies) receiving Medicare and Medicaid reimbursement to recognize the living will and power of attorney for health care as advance directives. Aetna Better Health of Louisiana requires our providers to comply with this act.

For additional information about the PSDA, please visit **www.gapna.org/patient-self-determination-act-psda**

Physician Orders for Life Sustaining Treatment (POLST) Act

Aetna Better Health of Louisiana requires providers to comply with the Physician Orders for Life Sustaining Treatment Act (POLST). The creation of this act allows members to indicate their preferences and instructions regarding life-sustaining treatment. This act implements the Physician's Order for Life-Sustaining Treatment (POLST) program. The POLST protocol requires a health care professional to discuss available treatment options with seriously ill members (or their advocate/family member), and these preferences are then documented on a standardized medical form that the member keeps with them.

The form must be signed by a member's attending provider or advanced practice nurse. This form then must become part of a member's medical record, as this form will follow the member from one healthcare setting to another, including hospital, home, nursing home, or hospice.

Submitting 148 Admission Forms

For individuals admitting to a nursing facility to receive post-acute care services, providers must submit 148 Admission forms via the Medicaid Provider Portal with the following information:

Payment Source = "Other"
Free form text = "Medicaid Managed Care – [specified health plan] for [dates of contract]"

Concerns

Complaints concerning noncompliance with advance directive requirements may be filed with Aetna Better Health of Louisiana as a grievance or complaint, or with the State of Louisiana Department of Health at **1-855-725-0288**.

Aetna Better Health of Louisiana processes claims for covered services provided to members in accordance with applicable policies and procedures and in compliance with applicable State and federal laws, rules, and regulations, and all **Louisiana Medicaid Provider Manuals**. Aetna Better Health of Louisiana will not pay claims submitted by a provider who is excluded from participation in LA Medicaid or LA Healthy Louisiana Programs, or any program under federal law, or is not in good standing with the Louisiana Department of Health (LDH). All providers must align with **Louisiana Medicaid Provider Manuals**, ABHLA policies, and be in compliance with applicable State and federal laws, rules, and regulations.

Aetna Better Health of Louisiana uses our business application system to process and adjudicate claims. Both electronic and manual claims submissions are accepted. To assist us in processing and paying claims efficiently, accurately, and timely, Aetna Better Health of Louisiana encourages providers to submit claims electronically. To facilitate electronic claims submissions, Aetna Better Health of Louisiana has developed a business relationship with Change Healthcare. Aetna Better Health of Louisiana receives Electronic Data Interchange (EDI) claims directly from this clearinghouse, processes them through pre-import edits to maintain the validity of the data, HIPAA compliance, and member enrollment, and then uploads them into our business application each business day. Within twenty-hour (24) hours of file receipt, Aetna Better Health of Louisiana provides production reports and control totals to trading partners to validate successful transactions and identify errors for correction and resubmission.

Encounters

Billing Encounters and Claims Overview

Our Claims Inquiry Claims Research (CICR) Department is responsible for claims adjudication, resubmissions, and claims inquiry/research.

Aetna Better Health of Louisiana is required to process claims in accordance with Medicare and Medicaid claim payment rules and regulations.

- Providers must use valid International Classification of Disease, 9th Edition, Clinical Modification (ICD-10 CM) codes, and code to the highest level of specificity. Complete and accurate use of The Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Current Procedural Terminology (CPT), 4th Edition, procedure codes are also required. Hospitals and providers using the Diagnostic Statistical Manual of Mental Disorders, 4th Edition, (DSM IV) for coding must convert the information to the official ICD-10 CM codes. Failure to use the proper codes will result in diagnoses being rejected in the Risk Adjustment Processing System. Important notes: The ICD10 CM codes must be to the highest level of specificity: assign three-digit codes only if there are no four-digit codes within that code category, assign four-digit codes only if there is no fifth-digit sub-classification for that subcategory and assign the fifth-digit sub-classification code for those sub-categories where it exists.
- Report all secondary diagnoses that impact clinical evaluation, management, and treatment.
- Report all relevant V-codes and E-codes pertinent to the care provided. An unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

Review of the medical record entry associated with the claim should obviously indicate all diagnoses that were addressed were reported.

Again, failure to use current coding guidelines may result in a delay in payment and rejection of a claim.

Rejected (Voided) Claims

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

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

The rejection letter shall indicate why the claim is being returned, including all defects or reasons known at the time the determination is made and at a minimum, must 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.

CMS Risk Adjustment Data Validation

Risk Adjustment Data Validation (RADV) is an audit process to verify the integrity and accuracy of risk-adjusted payment. CMS may require us to request medical records to support randomly selected claims to verify the accuracy of diagnosis codes submitted.

It is important for providers and their office staff to be aware of risk adjustment data validation activities because we may request medical record documentation. Accurate risk-adjusted payment depends on the accurate diagnostic coding derived from the member's medical record.

The Balanced Budget Act of 1997 (BBA) specifically required implementation of a risk-adjustment method no later than January 1, 2000. In 2000-2001, encounter data collection was expanded to include outpatient hospital and physician data. Risk adjustment is used to fairly and accurately adjust payments made to Aetna Better Health of Louisiana by CMS based on the health status and demographic characteristics of a member. CMS requires us to submit diagnosis data regarding physician, inpatient, and outpatient hospital encounters on a quarterly basis, at minimum.

The Centers for Medicare and Medicaid Services (CMS) uses the Hierarchical Condition Category (HCC) payment model referred to as CMS-HCC model. This model uses the ICD-10 CM as the official diagnosis code set in determining the risk-adjustment factors for each member. The risk factors based on HCCs are additive and are based on predicted expenditures for each disease category. For risk-adjustment purposes, CMS classifies the ICD-10 CM codes by disease groups known as HCCs.

Providers are required to submit accurate, complete, and truthful risk adjustment data to us. Failure to submit complete and accurate risk adjustment data to CMS may affect payments made to Aetna Better Health of Louisiana and payments made by Aetna Better Health of Louisiana to the provider organizations delegated for claims processing.

Certain combinations of coexisting diagnoses for a member can increase their medical costs. The CMS hierarchical condition categories HCC model for coexisting conditions that should be coded for hospital and physician services are as follows:

- Code all documented conditions that coexist at time of encounter/visit and that require or affect member care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Providers and hospital outpatient departments should not code diagnoses documented as "probable", "suspected", "questionable", "rule out" or "working" diagnosis. Rather, providers and hospital outpatient departments should code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Annually, CMS conducts a medical record review to validate the accuracy of the risk-adjustment data submitted by Aetna Better Health of Louisiana. Medical records created and maintained by providers must correspond to and support the hospital inpatient, outpatient, and physician diagnoses submitted by the provider to us. In addition, regulations require that providers submit samples of medical records for validation of risk-adjustment data and the diagnoses reported to CMS, as required by CMS. Therefore, providers must give access to and maintain medical records in accordance with Medicare laws, rules, and regulations. The Centers for Medicare and Medicaid Services (CMS) may adjust payments to us based on the outcome of the medical record review.

For more information related to risk adjustment, visit the Centers for Medicare and Medicaid Services website at **http://csscoperations.com/**.

Billing and Claims

When to Bill a Member

All providers must adhere to federal financial protection laws and are prohibited from balance billing any member beyond the member's cost sharing, if applicable.

A member may be billed **ONLY** when the member knowingly agrees to receive non-covered services under the Healthy Louisiana Program:

- Provider MUST notify the member in advance that the charges will not be covered under the program.
- Provider MUST have the member sign a statement agreeing to pay for the services and place the document in the member's medical record.

When to File a Claim

All claims and encounters must be reported to us, including prepaid services.

Timely Filing of Claim Submissions

In accordance with contractual obligations, claims for services provided to a member must be received in a timely manner. Our timely filing limitations are as follows:

- **New Claim Submissions** – Medicaid-only and third-party liability claims must be filed on a valid claim form within 365 days the date services (per HCAPPA) were performed, unless there is a contractual exception. For hospital inpatient claims, date of service means the date of discharge of the member.
- **Claim Resubmissions** – Claim resubmissions must be filed within 180 days from the date of adverse determination of a claim.
- **Retroactive Eligibility Claim Submissions** – Aetna Better Health of Louisiana shall not deny claims submitted in cases of retroactive eligibility for timely filing if the claim is submitted within one hundred and eighty (180) days from the member's linkage to Aetna Better Health of Louisiana. The exception to the retroactive eligibility timely filing requirements is such that the claim must be submitted to Aetna Better Health of Louisiana by the latter of the three hundred and sixty-fifth (365) calendar day from the date of service or one hundred and eighty (180) days from the member's linkage to Aetna Better Health of Louisiana.

Failure to submit claims and encounter data within the prescribed period may result in payment delay and denial.

Claims Processing Timeframes

- Within five (5) business days of receipt of a claim, Aetna Better Health of Louisiana shall 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.
- Ninety percent (90%) of all clean claims must be processed and paid or denied within fifteen (15) business days of the date of receipt.
- Ninety-nine percent (99%) of all clean claims must be processed and paid or denied within thirty (30) calendar days of the date of receipt.
- All pended claims must be fully adjudicated within sixty (60) calendar days of the date of receipt.

How to File a Claim

1) Select the appropriate claim form (refer to table below).

Service	Claim Form
Medical and professional services	**CMS 1500 Form**
Hospital inpatient, outpatient, skilled nursing, and emergency room services	**CMS UB-04 Form**
Dental services that are considered medical services (oral surgery, anesthesiology)	**CMS 1500 Form**

Instructions for completing the claim forms can be found on our website: **AetnaBetterHealth.com/Louisiana**.

2) Complete the claim form.
   a) Claims must be legible and suitable for imaging and microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.
   b) The claim form may be returned unprocessed (unaccepted) if illegible or poor-quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.
3) Submit original copies of claims electronically or through the mail (do NOT fax). To include supporting documentation, such as members' medical records, clearly label and send to Aetna Better Health of Louisiana at the correct address.
   a) Electronic Clearing House
   Providers who are contracted with us can use electronic billing software. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent, and minimizes clerical data entry errors. Additionally, a Level Two report is provided to your vendor, which is the only accepted proof of timely filing for electronic claims.
   - Change Healthcare is the EDI vendor we use.
   - Contact your software vendor directly for further questions about your electronic billing.
   - Contact our Provider Experience Department for more information about electronic billing.

   All electronic submission will be submitted in compliance with applicable law including HIPAA regulations and Aetna Better Health of Louisiana policies and procedures.

   b) Through the mail

Claims	Mail To	Electronic Submission
Medical	Aetna Better Health of Louisiana P.O. Box 982962 El Paso, TX 79998-2962	Through Electronic Clearinghouse: **www.changehealthcare.com/** Through Change HealthCare ConnectCenter (replaces WebConnect) **https://physician.connectcenter.changehealthcare.com/%23/site/home?payer=214562**

About ConnectCenter

Aetna Better Health of Louisiana uses Change Healthcare ConnectCenter. ConnectCenter is a web-based solution set that simplifies the everyday tasks the provider practices by integrating eligibility and benefits verification, claims and payment management as well as clinical tools all into one easy to use application. There are no provider costs for specialized software or per-transaction fees, even providers who previously only interfaced by submitting claims manually may utilize ConnectCenter for automated payer interaction.

Features

- Secure personalized web portal for submitting providers
- Automated electronic batch claim submission & real-time patient eligibility, benefit verification, referrals, pre-certs, authorizations, claim inquiry and more
- Fast implementation
- Real-time provider enrollment offers immediate electronic capability

Benefits

- Improves auto-adjudication rates

- Increases automation and improves efficiency
- Reduces call center volumes and associated expenses
- Eliminates requirement for capital investments in IT and staffing related to internal portal development and maintenance
- Drives providers directly to payers' websites
- Improves provider satisfaction

Please visit Change Healthcare to gain access:
https://physician.connectcenter.changehealthcare.com/#/register/step3/oIY_X8NzZHcrkPfJqbEVTK-LPAaFKKob1A-RTrFGdbd2tn0KehmN3z0fG39ooGS0

Correct Coding Initiative

Aetna Better Health of Louisiana follows the same standards as NCCI's Medicaid performs edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, please feel free to visit **www.cms.hhs.gov/NationalCorrectCodInitEd/.**

Aetna Better Health of Louisiana utilizes Claim Check as our comprehensive code auditing solution that will assist payers with proper reimbursement. Correct Coding Initiative guidelines will be followed in accordance with CMS and pertinent coding information received from other medical organizations or societies. Additional information will be released shortly regarding provider access to our unbundling software through Clear Claim Connection.

Clear Claim Connection is a web-based stand-alone code auditing reference tool designed to mirror our comprehensive code auditing solution through ClaimCheck. It enables us to share with our providers the claim auditing rules and clinical rationale inherent in ClaimCheck.

Providers will have access to Clear Claim Connection through our website through a secure login. Clear Claim Connection coding combinations can be used to review claim outcomes after a claim has been processed. Coding combinations may also be reviewed prior to submission of a claim so that the provider can view claim auditing rules and clinical rationale prior to submission of claims.

Correct Coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Incorrect Coding

Examples of incorrect coding include:

- "Unbundling" - Fragmenting one service into components and coding each as if it were a separate service
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate
- Downcoding a service in order to use an additional code when one higher level, more comprehensive code is appropriate

Modifiers

Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. Aetna Better Health of Louisiana can request copies of operative reports or office notes to verify services provided. Always include all valid primary and secondary modifiers when billing. Common modifier issue clarification is below:

- **Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service** - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the

comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 25 is used with Evaluation and Management codes and cannot be billed with surgical codes.

- **Modifier 26 – Professional Component of a procedure** - Professional portion only of a procedure that typically consists of both a professional and a technical component (e.g., interpretation of laboratory or radiology procedures performed by another provider); ABHLA does not reimburse both the professional and technical component on the same procedure. (See **Modifier TC**.)
- **Modifier 47 -** Delivering Physician Anesthesia provided by delivering physician
  Modifier 52 - Delivering Physician or Anesthesiologist Reduced services
- **Modifier 50 – Bilateral Procedure** - If no code exists that identifies a bilateral service as bilateral, you may bill the component code with modifier 50. We follow the same billing process as CMS and HFS when billing for bilateral procedures. Services should be billed on one line reporting one unit with a 50 modifier.
- **Modifier 57 – Decision for Surgery** – must be attached to an Evaluation and Management code when a decision for surgery has been made. We follow CMS guidelines regarding whether the Evaluation and Management will be payable based on the global surgical period. CMS guidelines found in the Medicare Claims Processing Manual, Chapter 12 Physicians/Nonphysician Practitioners indicate: *"Carriers pay for an evaluation and management service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses CPT modifier "-57" to indicate that the service resulted in the decision to perform the procedure. Carriers may not pay for an evaluation and management service billed with the CPT modifier "-57" if it was provided on the day of or the day before a procedure with a 0 or 10-day global surgical period."*
- **Modifier 59 – Distinct Procedural Services** - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499). CMS has defined four new HCPCS modifiers to selectively identify subsets of Distinct Procedural Services (-59 modifier) as follows:
  XE Separate Encounter, a service that is distinct because it occurred during a separate encounter
  XS Separate Structure, a service that is distinct because it was performed on a separate organ/structure
  XP Separate Practitioner, a service that is distinct because it was performed by a different practitioner
  XU Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service
  AA Anesthesiologist Anesthesia services performed personally by the anesthesiologist
  QY Anesthesiologist Medical direction* of one CRNA
  QK Anesthesiologist Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
  QS Anesthesiologist or CRNA Monitored Anesthesia Care Service** **The QS modifier is a secondary modifier only and must be paired with the appropriate anesthesia provider modifier (either the anesthesiologist or the CRNA). The QS modifier indicates that the provider did not introduce the epidural catheter for anesthesia, but did monitor the recipient after catheter placement
  QX CRNA service with direction by an anesthesiologist
  QZ CRNA service without medical direction by an anesthesiologist *
- **Modifier 62 –** two surgeons Performance of procedure requiring the skills of two surgeons
- **Modifier 66 –** surgical team performance of highly complex procedure requiring the concomitant services of several physicians (transplants)
- **Modifier 79 –** unrelated procedure or service by the same physician during the postoperative period
- **Modifier 80 –** assistant surgeons
- **Modifier AS –** First Assistant in surgery
- **Modifier GT** telemedicine Services provided via interactive audio and video telecommunications system
- **Modifier Q5 – Reciprocal Billing Arrangement** Services provided by a substitute physician on an occasional reciprocal basis not over a continuous period of longer than 60 days. Does not apply to substitution within the same group.
- **Modifier QW –** Laboratory required when billing certain laboratory codes
- **Modifier TC** – Technical Component of a procedure. ABHLA does not reimburse technical component (TC modifier) on straight Medicaid claims. Reimbursement is not allowed for both the professional component and full service on the same procedure.

- **Modifier TH – Prenatal** Visits Required to indicate E&M pre-natal services rendered in the MD office. This will also exempt the service from the adult evaluation and management visit limit.

Please refer to your Current Procedural Terminology (CPT) Manual for further detail on all modifier usage.

Checking Status of Claims
Providers may check the status of a claim by accessing our secure website or by calling the Claims Inquiry Claims Research (CICR) Department. To check the status of a disputed, resubmitted, and reconsidered claim, please contact the CICR Department.

Payment Adjustments for Dis-enrolled Members
For members dis-enrolled due to the validation of a duplicate Medicaid ID, Aetna Better Health of Louisiana shall not recover claim payments under the retroactively dis-enrolled member's ID if the remaining valid ID is linked to another MCO or FFS. Aetna Better health of Louisiana shall subrogate to the MCO that paid the claim(s) for the dates of service.

Payment Continuation of Higher Level Services
Aetna Better Health of Louisiana shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless Aetna Better Health of Louisiana can provide the service through an in-network or out-of-network provider for a lower level of care.

Payment to Providers
At a minimum, Aetna Better Health of Louisiana shall run one (1) provider payment cycle per week, on the same day each week.

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

Online Status through Aetna Better Health of Louisiana's Secure Website
Aetna Better Health of Louisiana encourages providers to take advantage of using our online Provider Secure Web Portal at **AetnaBetterHealth.com/Louisiana**, as it is quick, convenient and can be used to determine status (and receipt of claims) for multiple claims, paper and electronic. The Provider Secure Web Portal is located on the website. Provider must register to use our portal. Please see **Provider Enrollment, Responsibilities, & Important Info** for additional details surrounding the Provider Secure Web Portal.

Calling the Claims Inquiry Claims Research Department
The Claims Inquiry Claims Research (CICR) Department is also available to:
- Answer questions about claims.
- Assist in resolving problems or issues with a claim.
- Provide an explanation of the claim adjudication process.
- Help track the disposition of a particular claim.
- Correct errors in claims processing:
  - Excludes corrections to prior authorization numbers (providers must call the Prior Authorization Department directly).
  - Excludes rebilling a claim (the entire claim must be resubmitted with corrections.
    Please be prepared to give the service representative the following information:
    - Provider name or National Provider Identification (NPI) number with applicable suffix if appropriate
    - Member name and member identification number
    - Date of service.
    - Claim number from the remittance advice on which you have received payment or denial of the claim.

Claim Resubmission
Providers have 180 days from the paid date to resubmit a revised version of a processed claim. The review and reprocessing of a claim does not constitute reconsideration or claim dispute.

Providers may resubmit a claim that:
- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors

Include the following information when filing a resubmission:
- Use the Resubmission Form located on our website.
- An updated copy of the claim. All lines must be rebilled.
- A copy of the original claim (reprint or copy is acceptable).
- A copy of the remittance advice on which the claim was denied or incorrectly paid
- Any additional documentation required.
- A brief note describing requested correction
- Clearly label as "Resubmission" at the top of the claim in black ink and mail to appropriate claims address.

Resubmissions may not be submitted electronically. Failure to mail and accurately label the resubmission to the correct address will cause the claim to deny as a duplicate.

Please note: Providers will receive an EOB when their disputed claim has been processed. Providers may call our CICR Department during regular office hours to speak with a representative about their claim dispute. The CICR Department will be able to verbally acknowledge receipt of the resubmission, reconsideration, and the claim dispute. Our staff will be able to discuss, answer questions, and provide details about status. Providers can review our Secure Web Portal to check the status of a resubmitted/reprocessed and adjusted claim. These claims will be noted as "Paid" in the portal. To view our portal, please click on the portal tab, which is located under the provider page, which can be found on the following website: **AetnaBetterHealth.com/Louisiana.**

If Aetna Better Health of Louisiana or LDH or its subcontractors discover errors made by Aetna Better Health of Louisiana when a claim was adjudicated, Aetna Better Health of Louisiana shall make corrections and reprocess the claim within fifteen (15) calendar days of discovery, or if circumstances exist that prevent Aetna Better Health of Louisiana from meeting this time frame, a specified date shall be approved by LDH. Aetna Better Health of Louisiana will automatically recycle all impacted claims for all providers within 15 days and will not require the provider to resubmit the impacted claims.

Claim Recoupments
Aetna Better Health of Louisiana shall provide written prior notification to a provider of its intent to recoup any payment.

For members dis-enrolled due to invalidation of a duplicate Medicaid ID, Aetna Better Health of Louisiana shall not recover claim payments under the retroactively dis-enrolled member's ID if the remaining, valid ID is also linked to the same MCO for the retroactive disenrollment period. Aetna Better Health of Louisiana will work with the specific MCO and shall identify these duplicate Medicaid IDs for a single member and resolve the duplication so that histories of the duplicate records are linked or merged.

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 the MCO. The MCO shall initiate recoupments of payments to providers within 60 days of the date LDH notifies the MCO of the change. The MCO shall instruct the provider to resubmit the claim(s) to the Medicaid fee-for-service program (if applicable).

Billing Corrected Claims
If a provider submits a claim that is found to have incorrect information or charges that need to be added or corrected, then the provider must submit a corrected claim to replace the previously submitted claim. Instructions on how to submit a corrected claim are outlined below.

Correcting Claims
Providers have 180 days from the retracted date to submit a corrected version of the processed claim. The review and reprocessing of a claim do not constitute reconsideration or claim dispute.
Providers submitting corrected claims should ensure that the claim is clearly identified as a replacement or a cancellation.

- CMS-1500 Claims
  - Designate the frequency type of the claim with one of the following qualifier codes in the 2300 Loop of the CLM segment CLM05-03:
    - 7 – REPLACEMENT (Replace a prior claim.)
    - 8 – VOID (Void or cancel a prior claim.)
  - Enter the original claim number from the remittance advice in the 2300 loop of the REF segment.
- UB04 Claims
  - Designate the bill type of the claim with one of the following as the third digit for "frequency" in the 2300 Loop of the CLM segment CLM05-01:
    - 7 – REPLACEMENT (Replace a prior claim.)
    - 8 – VOID (Void or cancel a prior claim.)
  - Enter the original claim number from the remittance advice in the 2300 loop of the REF segment.

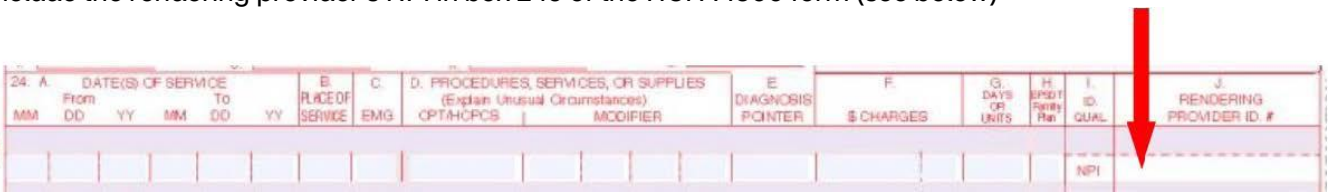
Instruction for Specific Claim Types

Aetna Better Health of Louisiana General Claims Payment Information
Our claims are always paid in accordance with the terms outlined in your provider contract. Prior authorized services from Non-Participating Health Providers will be paid in accordance with Original Medicare claim processing rules.

Applied Behavioral Analysis (ABA) Claims
ABA-based services are available to Medicaid recipients under 21 years of age. Our claims team will use the ABA description code and fee schedule found on the Louisiana Medicaid Fee Schedule website for billing and payment of claims.

Unlicensed Providers of Mental Health Rehabilitation Services
For a claim to be considered by an unlicensed provider for MHR services the provider must:

Include the rendering provider's NPI in box 24J of the HCFA 1500 form (see below)



Note that any claim received by Aetna Better Health of Louisiana will be denied if the rendering provider's NPI number is not on the claim OR if the rendering provider (licensed or unlicensed) is not credentialed with Aetna Better Health of Louisiana.

Skilled Nursing Facilities (SNF)
Providers submitting claims for SNFs should use CMS UB-04 Form.

Providers must bill in accordance with standard Medicare RUGS billing requirement rules for Aetna Better Health of Louisiana, following consolidated billing. For additional information regarding CMS Consolidated Billing, please refer to the following CMS website address: **www.cms.gov/SNFPPS/05_ConsolidatedBilling.asp**

Clinical Laboratory Improvement Amendments (CLIA) Claims
All professional service and independent laboratory providers are 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. Providers submitting claims for CLIA should use a CMS 1500 form.

Home Health Claims

Providers submitting claims for Home Health should use a CMS UB-04 form not a CMS 1500.
Skilled nursing codes as part of home health providers must bill in accordance with contract. Non-Participating Health Providers must bill according to CMS HHPPS requirement rules for Aetna. For additional information regarding CMS Home Health Prospective Payment System (HHPPS), please refer to the following CMS website address: **www.cms.gov/HomeHealthPPS/**

Rate Modifiers for Extended Home Health

Modifiers are available for routine home health and EHH (beneficiaries aged 0 through 20), to reflect specific scenarios as indicated in the table below. All modifier requests must be submitted with the PA and approved in order to be reimbursed. Refer to the Louisiana Medicaid Home Health Services Fee Schedule at **www.lamedicaid.com**

Modifier	Modifier Name
U2	Second Daily Visit
U3	Third Daily Visit
TT	Multiple Beneficiaries in the Same Setting
TG	High Complexity
TN	Rural/Outside Area
TV	Weekends/Holidays
UH	Services Provided in the Evening (6 PM – 11:59 PM)
UJ	Services Provided at Night (12 AM – 5:59 AM)
TU	Overtime (DOES NOT REQUIRE PA)

The above modifiers address enhanced rates for situations in which two beneficiaries are cared for simultaneously (TT), for children in EHH with high medical needs (TG), for overnight shifts for EHH (UH, UJ) for weekend/holiday shifts for EHH (TV), and for EHH services in rural areas (TN). These rate modifiers may be used in applicable circumstances to provide an enhanced reimbursement rate to home health providers in order to facilitate fully staffing prior approved EHH services for class members.

A home health agency may also submit claims using the TU modifier to identify hours for an EHH enrollee that were paid as overtime to the nurse delivering the care. This modifier shall not require prior authorization but must be for hours already authorized for the enrollee. When billing, this modifier may be used in addition to any other authorized modifiers (e.g., TG) for procedure codes S9123 and S9124, but shall be paid at a minimum of 1.5 times the base rate of the procedure code.

The use of this modifier is subject to post-payment review. ABHLA requires home health agencies to maintain all necessary documentation to support the use of this modifier. Non-compliance with written policy may result in recoupment and additional sanctions, as deemed appropriate by Louisiana Medicaid.

Louisiana Medicaid has a published Home Health Services Fee Schedule that includes modifiers with enhanced rates for situations in which two beneficiaries are cared for simultaneously, for children in EHH with high medical needs, for overnight shifts for EHH, for weekend shifts for EHH, for holiday shifts for EHH, and for EHH services in rural areas. These rate modifiers may be used in applicable circumstances to provide an enhanced reimbursement rate to home health providers in order to facilitate fully staffing prior approved EHH services for class members.

Durable Medical Equipment Reimbursement

For DME claims, both the ordering and referring providers must be enrolled with LA Medicaid in order for the claim to pay or encounter to be accepted. Additionally, an individual provider should be listed as the ordering or referring provider. Claims or encounters listing a group or clinic as the ordering or referring provider will be denied.

Unless otherwise stated on the LA Medicaid DME Fee Schedule, the reimbursement for all DME will be the lesser of the following (per the Centers for Medicare and Medicaid Services):

1. Seventy percent (70%) of the Medicare fee schedule for all procedure codes that were listed on the Medicare fess schedule and at the same amount for the HIPAA compliant codes which replaced them; or
2. Seventy percent (70%) of the Medicare fee schedule under which the procedure code first appeared; or
3. Seventy percent (70%) of the manufacturer's suggested retail price (MSRP) amount; or
4. Billed charges if the lesser amount; or
5. If an item is not available at the rate of seventy percent (70%) of the applicable established flat fee or seventy percent (70%) of the MSRP, the flat fee that will be utilized is the lowest cost at which the item has been determined to be widely available by analyzing usual and customary fees charged in the community.

Durable Medical Equipment (DME) Rental Claims

Providers submitting claims for Durable Medical Equipment (DME) Rental should use CMS 1500 Form.

DME rental claims are only paid up to the purchase price of the durable medical equipment.

Units billed for the program equal 1 per month. Units billed for Medicaid equal the amount of days billed. Since appropriate billing for CMS is 1 Unit per month, in order to determine the amount of days needed to determine appropriate benefits payable under Medicaid, the claim requires the date span (from and to date) of the rental. Medicaid will calculate the amount of days needed for the claim based on the date span.

Same Day Readmission

Providers submitting claims for inpatient facilities should use CMS UB-04 Form.
There may be occasions where a member may be discharged from an inpatient facility and then readmitted later that same day. We define same day readmission as a readmission with twenty-four (24) hours.

> ***Example:*** *Discharge Date: 10/2/10 at 11 AM*
> *Readmission Date: 10/3/10 at 9 AM*

Since the readmission was within twenty-four (24) hours, this would be considered a same day readmission per above definition.

Portable X-ray Claims

ABHLA does not reimburse for technical components for these services as a separate part of the service. Providers billing for these services must bill a full component only.

Transportation of portable x-ray equipment is reimbursable only when the equipment used is actually transported to the location where x-ray services are provided. ABHLA will not reimburse for the transportation of the portable x-ray equipment when the x-ray equipment is stored at a facility for use as needed.

ABHLA reimburses only one transportation payment per trip to a facility or location for a single date of service. Providers should make every effort to schedule all recipients at a single location during a single trip to that location. The physician's order for portable x-ray services must clearly state the following:

- suspected diagnosis or reason the x-ray is required
- area of the body to be exposed
- number of radiographs ordered
- precise views needed.

Portable x-ray units transported to a recipient's residence are to be billed with the Place of Service (POS) as the location where the service has been rendered, rather than using POS 15 (Mobile Unit). The recipient's place of residence should be billed with the appropriate POS on the CMS-1500:

- 12 – the recipient's private home.
- 31 – a skilled nursing facility.
- 32 – a nursing facility.
- 54 – an intermediate care facility for the developmentally disabled.

ABHLA does not reimburse the following portable x-ray services:

- procedures involving fluoroscopy.
- procedures involving the use of contrast media.
- procedures requiring the administration of a substance to the recipient, the injection of a substance, or the spinal manipulation of the recipient.
- procedures requiring special technical competency and/or special equipment or materials.
- routine screening procedures such as annual physicals.
- procedures which are not of a diagnostic nature, e.g., therapeutic x-ray treatments.
- annual x-rays.
- portable x-ray services provided in a hospital.

Hospice Claims

The only claims payable during a hospice election period by Aetna Better Health of Louisiana would be additional benefits covered under Aetna Better Health of Louisiana that would not normally be covered under the covered services.

HCPCS Codes

There may be differences in what codes can be billed for Medicare versus Medicaid. We follow Medicare billing requirement rules, which could result in separate billing for claims under Aetna. While most claims can be processed under both Medicare and Medicaid, there may be instances where separate billing may be required.

Per LDH guidelines, ABHLA performs updates to its procedure file to include yearly HCPCS updates and to revise reimbursement rates for applicable physician-administered drugs and vaccines within 30 days of published Medicaid fee schedule changes.

Cervical Cancer Screening (Pap Test)

Collection of Pap test specimens is included in the reimbursement of the E&M service. A claim for a Pap test may be submitted only if the provider submitting the claim has the necessary laboratory equipment to perform the test in their office or facility. For those beneficiaries under the age of 21, it is the responsibility of the treating provider to submit the required documentation needed for billing to the laboratory provider. Providers of these services must submit hard copy supporting documentation to the fiscal intermediary to have the age restriction bypassed for a specific clinical situation. Claims filed with hard copy supporting documentation will pend to medical review for confirmation of the conditions that are considered medically necessary. The following claims processing conditions will also apply:

- If the hard copy documentation is not present, the claim for the test will be denied.
- If the hard copy supporting documentation is present and meets the clinical criteria, the claim will be allowed to continue normal processing.

Sterilization Claims

Ancillary provider claims can be paid if sterilization form is provided OR paid from the surgeons paid claim that includes the form.

Behavioral Health Service Claims (except FQHCs and RHCS)

All claims for services on the specialized behavioral health fee schedule require the use of the age modifiers: HA for child/adolescents and HB for adults.

Behavioral Health Service Claims (FQHCs and RHCs)

Effective for dates of service on or after 4/1/2021, all Behavioral Health services claims are submitted using the H2020 encounter code. In addition, the changes allow the billing of Evaluation and Management (E/M)-only codes by certain Provider Type (PT) and Provider Specialty (PS) combinations.

The following E/M codes are eligible for members living in nursing facilities and assisted living facilities when administered by providers with a psychiatric specialty:

99304	99305	99306	99307	99308	99309	99310	99324

99325	99326	99327	99328	99334	99335	99336	99337

Billing Example 1
Billing PT 72, 79, 87, and 95 with rendering provider types 31/6A-6F, AK/8E, AH/8E and 73/73 must render a behavioral health-specific service as listed in the Specialized Behavioral Health Fee Schedule to bill a behavioral health encounter (H2020).

For the following Provider Type/Provider Specialty combinations:

Provider Type	**Provider Specialty**
31 – Psychologist (LIC/MED) (IN-ST) 6A – Psychologist – Clinical	6B – Psychologist – Counseling 6C – Psychologist – School 6D – Psychologist – Developmental 6E – Psychologist – Non-Declared 6F – Psychologist – All Other
AK – Licensed Professional Counselor	8E – CSoC/Behavioral Health
AH – Licensed Marriage & Family Therapist	8E – CSoC/Behavioral Health
73 – Licensed Clinical Social Worker (IN-ST)	73 – Social Worker Enrollment

- T1015 or D0999 cannot be billed. Encounters will deny with edit 210 (provider not eligible).
- If an E/M service detail line (procedure code 90792 or 99202 through 99215) is submitted with an accepted H2020 and Specialized Behavioral Health (SBH) procedure code line, ONLY the E/M service detail line will be denied.
- If there are no accepted SBH service detail lines, the encounter will be denied with edit 136 (no eligible service).
- If there is not an accepted all-inclusive code H2020, the encounter will be denied with edit 136 (no eligible service).

Billing Example 2
Billing PT 72, 79, 87, and 95 with rendering provider types 31/6A-6F, AK/8E, AH/8E and 73/73, billing H2020 must also include an accepted SBH service detail line on the claim. E/M codes are not acceptable and will be denied at the line level. E/M procedure codes are 90792 or 99202 through 99215. SBH services are identified in the Specialized Behavioral Health Fee Schedule.

Billing Example 3
Billing PT 72, 79, 87, and 95 with rendering provider types 20/26, 20/2W, 78/26, 93/26, 94/26 and 31/6G billing H2020 must include an accepted E/M detail line (procedure codes between 99202 through 99215) OR accepted SBH service detail line. SBH services are identified in the Specialized Behavioral Health Fee Schedule.

For the following Provider Type/Provider Specialty combinations:

Provider Type	**Provider Specialty**
20 – Physician (IND & GP)	26 – Psychiatry 2W – Addiction Specialist
78 – Nurse Practitioner (IND & GP)	26 – Psychiatry
93 – Clinical Nurse Specialist	26 – Psychiatry
94 – Physician Assistant	26 – Psychiatry

31– Psychologist (LIC/MED) (IN-ST)	6G – Psychologist – Medical

- There must be an accepted H2020 line, and:
  - at least one accepted E/M detail line (procedure codes 99202 through 99215), or
  - at least one accepted SBH service detail line
- If there are no accepted/paid detail lines with at least one E/M service detail line or at least one SBH service detail line, the encounter will deny with edit 136 (no eligible service).
- Both SBH and E/M codes may be reported and accepted on the encounter.
- If H2020 is not accepted, the encounter will deny with edit 136 (no eligible service)
- The above provider type/specialty combinations are the only behavioral health providers allowed to be reimbursed for claims with an evaluation and management HCPCS code as the only detailed line.

Out-of-State (OOS) Inpatient Hospital Claims

ABHLA reimburses inpatient Out-of-State (OOS) hospital stays at the following rates:

- 60% of billed charges reimbursed for Children (ages 0 – 20)
- 40% of billed charges reimbursed for Adults (ages 21 and up)

For all inpatient OOS hospital stays, providers are required to provide ABHLA with an itemized list of billed charges. Providers who have entered into a Single Case Agreement (SCA) must also include the SCA with their claim. All inpatient OOS hospital claims may be subject to an independent review. All claims over $50,000 are reviewed by ABHLA's Finance department.

Please note the following requirements for electronic and paper claims submission for OOS inpatient hospital stays:

Electronic Claims

Initially, an electronic claim cannot be submitted with an itemized list. To submit an electronic claim for an OOS inpatient hospital stay:

1. Submit the claim via your electronic clearinghouse.
2. Wait for the clearinghouse to provide the 277CA, which includes your Claim ID.
3. When you receive the 277CA, locate the claim using the Claim ID and attach the itemized list and your SCA (if any) to the claim.

Paper Claims

Paper submissions must include the itemized list with the claim. A claim for an OOS inpatient hospital stay submitted without an itemized list and an SCA (where necessary) will be denied and must be resubmitted as a corrected claim. To submit a paper claim for an OOS inpatient hospital stay, mail the claim, the itemized list, and the SCA (if any) to:

Aetna Better Health of Louisiana
P.O. Box 982962
El Paso, TX 79998-2962

Social Determinants of Health (SDoH) Z-Codes

Aetna Better Health of Louisiana (ABHLA) is committed to reducing health inequities. As part of this commitment, ABHLA encourages the use of Z Codes to document Social Determinants of Health (SDOH), including access to food, access to transportation, literacy issues, and other social and economic issues.

Effective 12/13/2021, ABHLA began reimbursing a flat rate incentive payment of $30 for a one-time billing of Z Codes per claim per member encounter. To ensure receipt of this incentive payment, providers must:

- Bill CPT code G9919 with 1 unit and must include at least one of the Z codes listed below as a diagnosis on a claim.
  - CPT code G9919 must be billed in the amount of $30.00 to receive the incentive payment, this includes claims from Rural Health Clinics/Federally Qualified Health Clinics.

- CPT code G9919 must be linked and submitted on the same claim line level as the corresponding Z code(s) to be paid appropriately.
- Please refer to the below table for Z codes that are eligible for the incentive.

- Providers of all types may bill Z codes in the above manner for the flat rate reimbursement. ABHLA does not limit the provider type or specialty eligible to bill and receive the incentive. If a provider is eligible to bill for Medicaid services, has a valid NPI, and is appropriately credentialed to bill for the reported services, then the provider/group is eligible for the incentive.
- There is no limit to the number of Z codes which can be included on the claim. The flat rate incentive payment of $30 is per claim, not per diagnosis. The code can be billed for each encounter a member presents and is identified through screening as having a SDoH need.

The following Z Codes are valid for reimbursement when billed with CPT Code G9919:

Z Code	Description
Z55.0	Illiteracy and low-level literacy
Z55.1	Schooling unavailable and unattainable
Z55.2	Failed school examinations
Z55.3	Underachievement in school
Z55.4	Educational maladjustment and discord with teachers and classmates
Z55.5	Less than a high school diploma
Z55.8	Other problems related to education and literacy
Z55.9	Problems related to education and literacy, unspecified
Z56.0	Unemployment, unspecified
Z56.1	Change of job
Z56.2	Threat of job loss
Z56.3	Stressful work schedule
Z56.4	Discord with boss and workmates
Z56.5	Uncongenial work environment
Z56.6	Other physical and mental strain related to work
Z56.81	Sexual harassment on the job
Z56.82	Military deployment status
Z56.89	Other problems related to employment
Z56.9	Unspecified problems related to employment
Z57.0	Occupational exposure to noise
Z57.1	Occupational exposure to radiation
Z57.2	Occupational exposure to dust
Z57.31	Occupational exposure to environmental tobacco smoke
Z57.39	Occupational exposure to other air contaminants
Z57.4	Occupational exposure to toxic agents in agriculture
Z57.5	Occupational exposure to toxic agents in other industries
Z57.6	Occupational exposure to extreme temperature
Z57.7	Occupational exposure to vibration
Z57.8	Occupational exposure to other risk factors
Z57.9	Occupational exposure to unspecified risk factor
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing
Z59.2	Inadequate housing
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.5	Extreme poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support

Z Code	Description
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z59.9	Problem related to housing and economic circumstances, unspecified
Z60.0	Problems of adjustment to life-cycle transitions
Z60.2	Problems related to living alone
Z60.3	Acculturation difficulty
Z60.4	Social exclusion and rejection
Z60.5	Target of (perceived) adverse discrimination and persecution
Z60.8	Other problems related to social environment
Z60.9	Problem related to social environment, unspecified
Z62.0	Inadequate parental supervision and control
Z62.1	Parental overprotection
Z62.21	Child in welfare custody
Z62.22	Institutional upbringing
Z62.29	Other upbringing away from parents
Z62.3	Hostility towards and scapegoating of child
Z62.6	Inappropriate (excessive) parental pressure
Z62.810	Personal history of physical and sexual abuse in childhood
Z62.811	Personal history of psychological abuse in childhood
Z62.812	Personal history of neglect in childhood
Z62.813	Personal history of forced labor or sexual exploitation in childhood
Z62.819	Personal history of unspecified abuse in childhood
Z62.820	Parent-biological child conflict
Z62.821	Parent-adopted child conflict
Z62.822	Parent-foster child conflict
Z62.890	Parent-child estrangement NEC
Z62.891	Sibling rivalry
Z62.898	Other specified problems related to upbringing
Z62.9	Problem related to upbringing, unspecified
Z63.0	Problems in relationship with spouse or partner
Z63.1	Problems in relationship with in-laws
Z63.31	Absence of family member due to military deployment
Z63.32	Other absence of family member
Z63.4	Disappearance and death of family member
Z63.5	Disruption of family by separation and divorce
Z63.6	Dependent relative needing care at home
Z63.71	Stress on family due to return of family member from military deployment
Z63.72	Alcoholism and drug addiction in family
Z63.79	Other stressful life events affecting family and household
Z63.8	Other specified problems related to primary support group
Z63.9	Problem related to primary support group, unspecified
Z64.0	Problems related to unwanted pregnancy
Z64.1	Problems related to multiparity
Z64.4	Discord with counselors
Z65.0	Conviction in civil and criminal proceedings without imprisonment
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.3	Problems related to other legal circumstances
Z65.4	Victim of crime and terrorism
Z65.5	Exposure to disaster, war, and other hostilities
Z65.8	Other specified problems related to psychosocial circumstances
Z65.9	Problem related to unspecified psychosocial circumstances

For questions and support, please contact **LAProvider@Aetna.com** or **lockwooda@aetna.com**, or call **1-855-242-0802** and follow the prompts.

Child Support Enforcement

HB 434 (Act 319) Summary

A policy or procedure proposed by a managed care organization shall not be implemented unless the department has provided its express written approval to the managed care organization after the expiration of the public notice period (45 days). Where “policy or procedure" shall 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.

Remittance Advice

EFT/ERA Registration Services (EERS)

Effective February 2024, Aetna Better Health of Louisiana partnered with ECHO to offer providers a single platform to register for EFT/ERA service across all Aetna Better Health plans. Provider enrollment in EERS is required for electronic payment service.

To enroll in EERS, visit **Aetna Better Health/ECHO Provider EFT/ERA Enrollment portal**. For FAQs, visit the **ECHO Provider Payments Portal User Guide**. To contact ECHO regarding the EERS system, call 1-800-830-5831.

Provider Remittance Advice

Aetna Better Health of Louisiana generates checks weekly. Claims processed during a payment cycle will appear on a remittance advice (“remit”) as paid, denied, or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to verify proper tracking and posting of adjustments. We recommend that you keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission. Call our Provider Experience Department if you are interested in receiving electronic remittance advices.

The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates.

Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to Aetna Better Health of Louisiana for previous overpayments not yet recouped or funds advanced.
- The Processed Amount is the total of the amount processed for each claim represented on the remit.
- The Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment depending on the terms of the provider contract.
- The Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- The Refund Amount represents funds that the provider has returned to Aetna Better Health of Louisiana due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of REVERSED in the claim detail header with a non-zero Refund Amount listed.
- The Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- The Ending Balance represents any funds still owed to Aetna Better Health of Louisiana after this payment cycle. This will result in a negative Amount Paid.
- The Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically then the Electronic Funds Transfer (EFT) Reference # and EFT Amount are listed along with the

last four digits of the bank account the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.

- The Benefit Plan refers to the line of business applicable for this remit. Tax Identification Number (TIN) refers to the tax identification number.
- The Claim Header area of the remit lists information pertinent to the entire claim. This includes:
  - Member Name
  - ID
  - Birth Date
  - Account Number
  - Authorization ID, if Obtained
  - Provider Name
  - Claim Status
  - Claim Number
  - Refund Amount, if Applicable
- The Claim Totals are totals of the amounts listed for each line item of that claim.
- The Code/Description area lists the processing messages for the claim.
- The Remit Totals are the total amounts of all claims processed during this payment cycle.
- The Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information.

An electronic version of the Remittance Advice can be attained. In order to qualify for an Electronic Remittance Advice (ERA), you must currently submit claims through EDI and receive payment for claim by EFT. You must also have the ability to receive0 through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Please contact our Provider Experience Department for assistance with this process. Payment for the Program will be made on separate checks, one check from Medicare, and one check from Medicaid.

HB 424 (Act 330) Summary

Claim Denials

- Applies to: MCOs, MCO Subcontractors, FFS, and FFS Contractors
- Applies to claims denied based on an opinion or interpretation of one of the following:
  - Law
  - Regulation
  - Policy
  - Procedure
  - Medical criteria or guideline
- Requires that the following be provided along with the remittance advice (RA), whether produced in paper format or electronically:
  - Instructions for accessing the applicable law, regulation, policy, procedure, or medical criteria or guideline IF it is housed within the public domain; or
  - A copy of the applicable law, regulation, policy, procedure, or medical criteria or guideline.

Prior Authorization Criteria and Denials

- Applies to: MCOs, MCO Subcontractors, FFS, and FFS Contractors
- Prior authorization (PA) criteria must be:
  - Available online in an easily searchable format; or
  - Furnished to the provider with 24 hours of request.
  - Ex: Policy states that providers are able to access PA criteria at ANYTIME, prior to or after submitting a PA through the online searchable format provided OR by email request with a 24 hour response time.
- PA denial notices must be given to the provider in writing within 3 days of the denial decision.
  - Ex: Policy explicitly states this timeline.
- Applies to PAs denied based on an interpretation of one of the following:
  - Law
  - Regulation
  - Policy

- Procedure
- Medical criteria or guideline

- Requires that the following be provided in the PA denial notice:
  - Instructions for accessing the applicable law, regulation, policy, procedure, or medical criteria or guideline IF it is housed within the public domain; or
  - A copy of the applicable law, regulation, policy, procedure, or medical criteria or guideline.
  - Ex: The denial letter includes a hard copy of or INSTRUCTIONS to the applicable portion of the law, regulation, policy procedure or medical criteria or guideline that was used to make the determination.
  - OK: This treatment was denied based on the interpretation of this medical guideline (link provided), in section (section title provided), on page (page provided) and in paragraphs (paragraph provided).
  - NOT OK: This treatment was denied based on the interpretation of this medical guideline (link provided is general page or does not include instructions).

Claims Submission

Claims Filing Formats

Providers can elect to file claims with Aetna Better Health of Louisiana in either an electronic or a hard copy format. Claims must be submitted using either the CM 1500 or UB 04 formats, based on your provider type as detailed below.

Electronic Claims Submission

- In an effort to streamline and refine claims processing and improve claims payment turnaround time, Aetna Better Health of Louisiana encourages providers to electronically submit claims, through Change Healthcare.
- Please use the Payer ID number 128LA when submitting claims to Aetna Better Health of Louisiana for both CMS 1500 and UB 04 forms. You can submit claims by visiting Change Healthcare at **www.changehealthcare.com**. Before submitting a claim through your clearinghouse, please verify that your clearinghouse is compatible with Change Healthcare.

Important Points to Remember

- Aetna Better Health of Louisiana does not accept direct EDI submissions from its providers.
- Aetna Better Health of Louisiana does not perform any 837 testing directly with its providers but performs such testing with Change Healthcare.
- For electronic resubmissions, providers must submit a frequency code of 7 or 8. Any claims with a frequency code of 5 will not be paid.
- Providers must be ICD-10 compliance upon roll out.

Paper Claims Submission

Providers can submit hard copy CM 1500 or UB 04 claims directly to Aetna Better Health of Louisiana via mail to the following address:

Aetna Better Health of Louisiana
P.O. Box 982962
El Paso, TX 79998-2962

Risk Pool Criteria

If the claims paid exceed the revenues funded to the account, the providers will fund part or the entire shortfall. If the funding exceeds paid claims, part or all of the excess is distributed to the participating providers.

Encounter Data Management (EDM) System

Aetna Better Health of Louisiana uses an Encounter Data Management (EDM) System that warehouses claims data and formats encounter data to LDH requirements. The EDM System also warehouses encounter data from vendors, and formats it for submission to LDH. We use our state-of-the-art EDM System to monitor data for accuracy, timeliness, completeness, and we then submit encounter data to LDH. Our EDM System processes CMS1500, UB04 (or UB92), Dental, Pharmacy and Long Term Care claims and the most current coding protocols (e.g., standard CMS procedure or service codes, such as ICD-10, CPT-4, HCPCS-I, II). Our provider contracts require providers to submit claims on the approved claim form and each claim must contain the necessary data requirements. Part of our

encounter protocol is the requirement for providers to utilize NDC coding in accordance with the Department's requirements.

The EDM System has top-of-the-line functionality to accurately, and consistently track encounters throughout the submission continuum including collection, validation, reporting, and correction. Our EDM System is able to electronically accept a HIPAA-compliant 837 (I and P) electronic claim transaction, 835 Claim Payment/Advice transaction and the NCPDP D.O. or PAH transaction in standard format and we require our providers and their clearinghouses to send electronic claims in these formats.

We collect claims information from multiple data sources into the EDM System for processing, including data from our QNXT ™ claims adjudication system as well as data from third-party vendors under contract to process various claims, such as dental, vision, transportation, and pharmacy. Our EDM System accommodates all data sources and provides a single repository for the collection of claims/encounters. Through our EDM System, we conduct a coordinated set of edits and data checks and identify potential data issues at the earliest possible stage of the process. Below we describe in more detail the different checkpoints.

Claims Processing
Our business application system has a series of active claim edits to determine if the appropriate claim fields contain the required values. We deny, completely or in part, claims submitted without required information or with invalid information. The provider is required to resubmit the claim with valid information before they receive payment. After adjudication and payment, we export claims data from our business application system into our EDM System. Our Encounter Management Unit validates the receipt of all claims data into EDM System using a transfer validation report. The Encounter Management Unit researches, tracks, and reports any discrepancy until that discrepancy is completely resolved.

Pended Claims
If a clean claim is received, but additional information is required for adjudication, Aetna Better Health of Louisiana may pend the claim and request in writing (notification via e-mail, Web site/Provider Portal or an interim Explanation of Benefits satisfies this requirement) all necessary information such that the claim can be adjudicated within established timeframes.

Claims System Editing
Aetna Better Health of Louisiana shall have 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 to be complete no later than 30 days after notification, unless otherwise directed by LDH. This includes annual and other fee schedule updates.

Third Party Liability (TPL)
Pursuant to federal and state law, the Medicaid program by law is intended to be the payer of last resort. This means all other available Third Party Liability (TPL) resources must meet their legal obligation to pay claims before Aetna Better Health of Louisiana pays for the care of an individual eligible for Medicaid.

Aetna Better Health of Louisiana shall take reasonable measures to determine TPL.

Aetna Better Health of Louisiana shall coordinate benefits in accordance with 42 CFR §433.135, et seq. and La. R.S. 46:460.71, so that costs for services otherwise payable by Aetna Better Health of Louisiana are cost avoided or recovered from a liable party. The two methods used are cost avoidance and post-payment recovery. Aetna Better Health of Louisiana shall use these methods as described in federal and state law.

Establishing TPL takes place when Aetna Better Health of Louisiana receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or services delivered to a member.

If the probable existence of TPL cannot be established Aetna Better Health of Louisiana must adjudicate the claim. Aetna Better Health of Louisiana must then utilize post-payment recovery if TPL is later determined to exist which is described in further detail below.

The term "state" shall be interpreted to mean "MCO" for purposes of complying with the federal regulations referenced above. Aetna Better Health of Louisiana may utilize subcontractors to comply with coordination of benefit efforts for services provided pursuant to this contract.

For the eligible Medicaid population that is dually enrolled in Medicare, Medicaid-covered specialized behavioral health services that are not covered by Medicare shall be paid by Aetna Better Health of Louisiana. For dually eligible individuals, Medicare "crossover" claims (claims for services that are covered by Medicare as the primary payer) are excluded from coverage under the capitated rates. These services will be administered separately by the Fiscal Intermediary from the services covered under the capitation rates effective under this contract. In the event that a dually eligible individual's Medicare benefits have been exhausted as of the date of service on which a Medicare covered behavioral health service was provided, Medicaid will be considered primary. Claims for those services will no longer be considered "crossover" claims, and Aetna Better Health of Louisiana shall be responsible for payment. Specific payment mechanisms surrounding these populations shall be determined by LDH in the MCO Systems Companion Guide.

Aetna Better Health of Louisiana must update its system with daily TPL records sent from LDH's Fiscal Intermediary (FI) within one (1) business day of receipt. Aetna Better Health of Louisiana must reconcile its system with weekly TPL reconciliation files sent from LDH's FI within one (1) business day of receipt. If a P enrolled member is unable to access services or treatment until an update is made, Aetna Better Health of Louisiana must verify and update its system within four (4) business hours of receipt of an update request. Participants are persons aged 55 years or older, live in the PACE provider service area and are certified to meet nursing facility level of care and financially eligible for Medicaid long term care. Participation is voluntary and enrollees may disenroll at any time. P enrolled members are members enrolled with Aetna Better Health of Louisiana for Medical, Behavioral Health, Pharmacy and Transportation services. This includes updates on coverage, including removal of coverage that existed prior to the member's linkage to Aetna Better Health of Louisiana that impacts current provider adjudication or member service access (i.e. pharmacy awaiting TPL update to fulfill prescription). Such updates must be submitted to LDH Third Party Liability contractor on the Louisiana Department of Health Medicaid Recipient Insurance Information Update Form the same day the update is made in Aetna Better Health of Louisiana's system.

Prenatal Services, Labor & Delivery, and Postpartum Care

In compliance with the Bipartisan Budget Act of 2018 (Pub. L. 115-123) Aetna Better Health of Louisiana initiates standard coordination of benefits cost avoidance processes for prenatal services, labor and delivery, and postpartum care. Specifically, these Diagnosis Codes Prenatal Services will now be cost avoided.

Child Support Enforcement "Wait and See"

Aetna Better Health of Louisiana complies must comply with the Bipartisan Budget Act of 2018 (Pub. L. 115-123) which includes a "wait and see" period for claims provided to a Medicaid eligible individual whose health insurance is provided by an absent parent who is under the jurisdiction of the State Child Support Enforcement Agency are now subject to a "wait and see period." Payment for these claims can only be made after the required documentation is attached to a hard copy claim and submitted to ABHLA demonstrating that 100 days have elapsed since the provider billed the responsible third party and the provider still remains to be paid.

A provider can bill Medicaid only for the balance not paid for by the liable third party and the payment can only be made for up to the Medicaid allowable amount. Refer to the **Wait and See Provider Notice** for documentation requirements.

Preventive Pediatric Care "Pay and Chase"

Louisiana Medicaid uses the "pay and chase" method of payment for preventive pediatric care services and prescription drug services for individuals with health insurance coverage. Most providers are not required to file health insurance claims with private carriers when the service meets the pay and chase criteria. The Bureau of Health

Services Financing (BHSF) seeks recovery of insurance benefits from the carrier within 60 days after claim adjudication when the provider chooses not to pursue health insurance payments.

Service classes which do not require private health insurance claim filing by most providers* are:

- Preventive Pediatric Care Services diagnosis codes rendered to individuals under 21 years of age. *Hospitals are not included and must continue to file claims with health insurance carriers.
- EPSDT (Early and Periodic Screening, Diagnostics and Treatment) medical, vision, hearing screening services, and dental services
- EPSDT services for children with special needs (formerly referred to as school health services) which result from screening and are rendered by school boards
- Services which are a result of an EPSDT referral, indicated by entering "Y" in block 24H of the HCFA-1500 claim form or "1" as a condition code on the UB-92 (form locators 24-30)

Encounter Staging Area

One of the unique features of our EDM System is the Encounter Staging Area. The Encounter Staging Area enables the Encounter Management Unit to evaluate all data files from our business application system and third party vendors (e.g., Pharmacy Benefit Management, dental, transportation, or vision vendors) for accuracy and completeness prior to loading into the EDM System. We maintain encounters in the staging area until the Encounter Management Unit validates that each encounter contains all required data and populated with appropriate values.

Our Encounter Management Unit directs, monitors, tracks, and reports issue resolution. The Encounter Management Unit is responsible for tracking resolution of all discrepancies.

Encounter Data Management (EDM) System Scrub Edits

This EDM System feature allows the Encounter Management Unit to apply LDH edit profiles to identify records that may be unacceptable to the LDH. Our Encounter Management Unit is able to customize our EDM System edits to match the edit standards and other requirements of the LDH. This means that we can align our encounter edit configuration with the LDH's configuration to improve encounter acceptance rates.

Encounter Tracking Reports

Encounter Tracking Reports are another unique feature of our EDM System. Reports are custom tailored for each plan.

Our Encounter Management Unit uses a series of customized management reports to monitor, identify, track, and resolve problems in the EDM System or issues with an encounter file. Using these reports our Encounter Management Unit is able to identify the status of each encounter in the EDM by claim adjudication date and date of service. Using these highly responsive and functional reports, our Encounter Management Unit can monitor the accuracy, timeliness, and completeness of encounter transactions from entry into EDM System, submission to and acceptance by the Department. Reports are run to verify that all appropriate claims have been extracted from the claims processing system.

Data Correction

As described above, the Encounter Management Unit is responsible for the EDM System. This responsibility includes managing the data correction process should it be necessary to resubmit an encounter due to rejection of the encounter by the Department.

Our Encounter Management Unit uses two processes to manage encounter correction activities:

1) Encounters requiring re-adjudication and those where re-adjudication is unnecessary. If re-adjudication is unnecessary, the Encounter Management Unit will execute corrections to allow resubmission of encounter errors in accordance with the Department encounter correction protocol.

2) Encounter errors that require claim re-adjudication are reprocessed in the appropriate claim system, the adjusted claim is imported into the EDM for resubmission to the Department in accordance with the encounter correction protocol, which is tailored to the Department's requirements. The Encounter Data Management System (EDM) generates, as required, the appropriate void, replacement, and corrected records.

Although our data correction procedures enable the Encounter Management Unit to identify and correct encounters that failed the Department's acceptance process, we prefer to initially process and submit accurate encounters. We apply lessons learned through the data correction procedures to improve our EDM System scrub and edit described above. In this way, we will expand our EDM System scrub edits to improve accuracy of our encounter submissions and to minimize encounter rejections. This is part of our continuous process improvement protocol.

Our Encounter Management Unit is important to the timely, accurate, and complete processing and submission of encounter data to the LDH. Our Encounter Management Unit has specially trained correction analysts with experience, knowledge, and training in encounter management, claim adjudication, and claim research. This substantial skill base allows us to research and adjust encounters errors accurately and efficiently. Additionally, the unit includes technical analysts who perform the data extract and import functions, perform data analysis, and are responsible for oversight and monitoring of encounter files submissions to the LDH. The team includes a technical supervisor and a project manager to monitor the program.

Another critical step in our encounter data correction process is the encounter error report. We generate this report upon receipt of response files from the Department and give our Encounter Management Unit critical information to identify and quantify encounter errors by type and age. These data facilitate the monitoring and resolution of encounter errors and supports the timely resubmission of corrected encounters.

Common Observation Policy

The purpose of the outpatient hospital services program is to provide outpatient services to eligible Medicaid members performed on an outpatient basis in a hospital setting. ABHLA will reimburse up to forty-eight (48) hours of medically necessary care for a member to remain in an observational status. This time frame is for the physician to observe the member and to determine the need for further treatment, admission to an inpatient status, or for discharge. Observation and ancillary services do not require notification, precertification or authorization and will be covered up to forty-eight (48) hours.

Hospitals should bill the entire outpatient encounter, including Emergency Department (ED), Observation, and any associated services, on the same claim with the appropriate revenue codes, and all covered services are to be processed and paid separately. Any observation service over forty-eight (48) hours requires authorization. For observation services beyond forty-eight (48) hours that are not authorized, ABHLA will only deny the non-covered hours.

If a member is anticipated to be in observation status beyond forty-eight (48) hours, the hospital must notify ABHLA as soon as reasonably possible for potential authorization of an extension of hours. ABHLA will work with the provider to coordinate the provision of additional medical services prior to discharge of the member as needed. All observation status conversions to an inpatient hospital admission require notification to Aetna Better Health within one business day of the order to admit a member. All hospital facility charges on hospital day one are included in the inpatient stay and billed accordingly inclusive of emergency department/observation charges. Professional charges will continue to be billed separately.

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This chapter does not cover issues related to transportation. See Chapter 6: Medical Transportation for guidance related to resolving transportation issues.

Member Appeal and Grievance System Overview

Members or their representative that is designated in writing can file an appeal or grievance directly with Aetna Better Health verbally, in writing or by fax. A representative is someone who assists with the appeal or grievance on the member's behalf, including but not limited to a family member, friend, guardian, primary care physician (PCP), woman's health care provider (WHCP) or an attorney.

Representatives: A representative is a person who assists with the appeal on the member's behalf. The member must designate a representative in writing. **In all cases, when representatives, including a provider, file an appeal or grievance on behalf of a member the case is considered a member appeal or member grievance and is subject to the member appeal or grievance timeframes and policies.**

Members and their designated representatives, including providers, with written consent may also ask for **a State Fair Hearing through the Division of Administration, Administrative Law Judge Division.**

Aetna Better Health ensures that all members and providers are informed of the grievance, appeal, and State Fair Hearing procedures. This information is contained in the member handbook and provider manual. Forms used to file grievance, appeals and the link to access the State Fair Hearing site are available on our web site. Forms are also available in hard copy upon request. When requested, we give members reasonable assistance in completing forms and taking other procedural steps. Our assistance includes but is not limited to provider interpreter services and toll- free numbers that have adequate TTY/TTD and interpreter. Oral interpretation services and alternate formats are available to members at no cost. If you need help in another language, call **1-855-242-0802** (toll-free).

Notifying Members of Grievance System Process

Members are educated regarding the grievance system process through:

- Instructions in the Member Handbook:
  - The handbook is included in all new member welcome packets and mailed in time to reach the member within ten (10) days of receiving notification of the member's enrollment. Instructions also provide information regarding what to do in case of denial, reduction, suspension, or termination of services
- Articles in the Aetna Better Health member newsletters
- The Aetna Better Health website

Any changes to the grievance system process are submitted to the Louisiana Department of Health (LDH) for approval prior to implementation. Members are then notified at least thirty (30) calendar days in advance of any changes in Aetna Better Health's grievance or appeal policies, when possible.

Aetna Better Health complies with BBA rules and applicable state requirements policies on content, timing, and translation of all member information related to members' grievance rights.

Notifying Contractors and Providers of Grievance System Process

Information regarding the grievance system process is distributed to all contractors and to all in-network providers at the time they enter into a contract and to out-of-network providers within ten (10) calendar days of prior approval of a service or the date of receipt of a claim, whichever is earlier.

Aetna Better Health verifies that no punitive action is taken in retaliation against a member who requests an appeal or grievance or against a provider who requests an expedited resolution or supports a member's appeal or grievance. Providers may not discriminate or initiate disenrollment of a member for filing an appeal or grievance with Aetna Better Health.

Aetna Better Health's processes for resolving member appeals and grievances are described below.

Extensions
The decision making timeframe on a standard or expedited appeal may be extended by fourteen (14) calendar days if the member requests the extension or if Aetna Better Health believes that there is a need for additional information and that obtaining the information is in the member's best interest.

Aetna Better Health we will make reasonable attempts to give oral notification of delay and will send written notice of extension within two (2) calendar days of the decision to delay and within the original standard or expedited timeframe to the affected parties. The written notice of delay will include the member's right to file a grievance if they disagree with Aetna Better Health taking an extension.

Member Grievance Process
Standard Grievance
The member or the member's authorized representative, including providers, may file a grievance. A grievance is an expression of dissatisfaction regarding any aspect of Aetna Better Health policies, procedures, or services and/or a provider care or service. This includes quality of care concerns. Grievances may be filed with Aetna Better Health orally or in writing by the member or their designated representative at any time.

Aetna Better health will acknowledgement grievances within five (5) business days of receipt. The letter will provide information about their grievance rights and will include, but no limited to:

- Members right to provide more information and documents for their grievance either in person or in writing
- Members right to view their grievance file
- Members right to be present either onsite or via telephone when the Grievance Committee reviews their grievance

Aetna Better Health resolves standard grievances within ninety (90) calendar days from receipt. The resolution letter will be mailed to the member explaining the reason for the decision. The grievance process is not eligible for an extension of the timeframe.

Expedited Grievances
Aetna Better Health resolves all grievances effectively and efficiently. Expedited grievances occur in situations where the member was denied expedited processing of a prior authorization or appeal; or when Aetna Better Health took an extension on the decision-making timeframe for a prior authorization or on an appeal. A member or his/her authorized representative, including providers, may request an expedited grievance either orally or in writing. Expedited grievances are resolved within seventy-two (72) hours of receipt.

For expedited grievances, Aetna Better Health makes reasonable effort to provide oral notice of the grievance decision followed by written notification. Members are advised in writing of the outcome of the investigation of all grievances within two (2) days of its resolution. The Notice of Resolution includes the decision reached and the reasons for the decision and the telephone number and address where the member can speak with someone regarding the decision.

How to File a Grievance
Grievances may be filed by calling Member Services at **1-855-242-0802**, for the hearing-impaired LA Relay 7-1-1 or they may be submitted in writing via fax to: **860-607-7657** or postal mail to:

Aetna Better Health
Appeal and Grievance Department
P.O. BOX 81139
5801 Postal Rd
Cleveland, OH 44181

Member Appeal Process
Standard Appeal
Appeals are a formal request for Aetna Better Health to reconsider an adverse benefit decision.

Members or their designated representative can file a standard appeal with Aetna Better Health orally or in writing within sixty (60) calendar days from the postmark on the Aetna Better Health Notice of Adverse benefit determination, also called the Notice of Action (NOA).

A written consent form signed by the member allowing the provider or representative to file an appeal on the member's behalf must be submitted PRIOR to or with the pertinent documents before an appeal process can begin. The appeals process will include, as parties to the appeal, the member and his or her representative or the legal representative of a deceased member's estate.

The Aetna Better Health Notice of Action (NOA) informs members and providers of the following:

- Our decision and the reasons for our decision
- A clear explanation of further appeal rights and the time frame for filing an appeal
- The availability of assistance in filing an appeal
- The toll-free numbers that the member can use to file an appeal by phone
- The procedures for exercising the rights to appeal or request a State fair hearing
- That the member may represent himself or designate a legal counsel, a relative, a friend, a provider or other spokesperson to represent them at any time during the appeal process
- Notice of any actions required of Aetna Better Health
- Notice of our opportunity to use the dispute resolution process as described in the Provider Agreement
- The specific regulations that support, or the change in Federal or State law that requires the action
- Members may request that their benefits continue through the appeal process, when all of the following criteria are met:
  - The member or provider on behalf of the member files the appeal within ten (10) calendar days of the postmarked notice of adverse action or prior to the effective date of Aetna Better Health's notice of adverse action
  - The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
  - The services were ordered by an authorized provider
  - The original period covered by the initial authorization has not expired
  - The member requests extension of benefits
- The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member
- The circumstances under which expedited resolution is available and how to request it
- Any appeal rights that the state chooses to make available to providers to challenge the failure of the organization to cover a service

Aetna Better Health will acknowledge the appeal within five (5) business days of receipt. An acknowledgement letter will be sent to the member or authorized member representative and the member's practitioner. The letter will provide information about their appeal rights and will include a request for any additional clinical documentation that could support the services requested. The acknowledgement letter includes, but is not limited to:

- Members right to provide more information and documents for their appeal either in person or in writing
- Members right to view their appeal file
- Members right to be present either onsite or via telephone when the Appeal Committee reviews their appeal

Aetna Better Health resolves standard appeals within thirty (30) calendar days of receipt. The member or their designated representative may extend the timeframe at any time. If we are unable to make a decision on the appeal within thirty (30) days, we may ask to extend the appeal decision date by fourteen (14) calendar days. In these cases, we will provide information describing the reason for the delay in writing to the member and the appeal will be resolved within forty-four (44) days from receipt.

All parties to the appeal are advised in writing of the outcome of the investigation of the appeal within two (2) calendar days of the decision. The Appeal Decision letter includes the decision reached, the reasons for the decision

and the telephone number and address where the member can speak with someone regarding the decision. The notice also tells a member how to obtain information on filing a State Fair Hearing.

The decision letter, including an explanation for the decision, is mailed to the member within two (2) calendar days of the Appeal Committee's decision

- If Aetna Better Health does not agree with the member's appeal and issues a denial decision, and the member continued to receive services, the member may be responsible for cost of services received during the appeal process.
- If Aetna Better Health reverses our original decision and approves the appeal, services will begin immediately
- If Aetna Better Health does not agree with the member's appeal, the member can ask for a Medicaid State Fair Hearing and request to receive benefits while the hearing is pending

Expedited Appeal

Aetna Better Health resolves all appeals as quickly as the member's health condition requires. On occasion, certain issues may require a quick decision. These issues, known as expedited appeals, occur in situations where the member's provider or Aetna Better Health determines that waiting the standard appeal timeframe could seriously harm the member's health. A member or their designated representative, including providers, may request an expedited appeal either orally or in writing. Expedited appeals are resolved within seventy-two (72) hours of receipt.

If Aetna Better Health determines that waiting the standard timeframe will not harm the member's health the member's appeal will be transferred to a standard appeal and will be decided within the normal thirty (30) calendar day timeframe. We make reasonable effort to provide oral notice that the appeal is being processed following the standard timeframe and we send written notification within two (2) calendar days with this information. The notification includes information that the member may file a grievance if they are dissatisfied with the denial of expedited processing time of their appeal.
Note: Post service items or services are not eligible for expedited processing.

How to File an Appeal

Appeals may be filed by calling Member Services at **1-855-242-0802**, for the hearing-impaired LA Relay 7-1-1 or theymay be submitted in writing via fax to: **860-607-7657** or postal mail to:

Aetna Better Health of Louisiana
Appeal and Grievance Department
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

Failure to Make a Timely Decision

Appeals must be resolved within stated timeframes and all parties must be informed of Aetna Better Health's decision. If a determination is not made by the above timeframes, the member's request will be deemed to havebeen approved as of the date upon which a final determination should have been made.

State Fair Hearing

Members or their designated representative, including a provider acting on their behalf, with written consent may request a State Fair Hearing through Division of Administrative Law after the appeal with Aetna Better Health. Members have one-hundred-twenty (120) calendar days to file following receipt of the appeal decision letter. Information on how to submit a State Fair Hearing appeal is included in Appeal Decision Letter.

The request for a State Fair Hearing must be submitted in writing using one of the following options:

To Submit by Mail:
Division of Administrative Law – HH Section
PO Box 4189
Baton Rouge, LA 70821-4189

To Submit by Fax:
225-219-9823
To submit Online Request Form:
www.adminlaw.state.la.us/forms.htm

Members may request that their benefits continue through the State Fair Hearing process, when all of the following criteria are met:

- The member or provider on behalf of the member files the appeal within ten (10) calendar days of the postmarked notice of adverse action or prior to the effective date of notice of adverse action
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider
- The original period covered by the initial authorization has not expired
- The member requests extension of benefits

The department renders the final decision and will notify all parties. If the decision agreed with Aetna Better Health's previous decision, and the member **continued to receive services,** the member may be responsible for cost of services received during the State Fair Hearing. If the State Fair Hearing decision favors the member, then Aetna Better Health authorize items/services within seventy-two (72) hours of the receipt of the decision.

Provider Appeal and Complaint System Overview

Aetna Better Health and the contracted health care provider are responsible for resolving any contractual disputes that may arise between the two (2) parties through the Provider Complaint System process; no complaint will disrupt or interfere with the provisions of services to the member. Provider disputes, complaints, and appeals will be settled according to the terms of the provider's contractual agreement.

Aetna Better Health verifies that no punitive action is taken in retaliation against a member who requests an appeal or complaint or against a provider who requests an expedited resolution or supports a member's appeal or grievance. Providers may not discriminate or initiate disenrollment of a member for filing an appeal or grievance with Aetna Better Health.

A network provider, acting on behalf of a member, and with the member's written consent, may file a grievance or appeal on the member's behalf. **In all cases, when a provider files on behalf of a member the case is considered a member appeal or grievance and is subject to the member appeal or grievance timeframes and policies.**

Representatives must be designated in writing. A representative is a person who assists with the appeal on the member's behalf, including but not limited to, a family member, friend, guardian, primary care physician (PCP), woman's health care provider (WHCP) or an attorney. The member must designate a representative in writing. **In all cases, when representatives, including a provider, file an appeal or grievance on behalf of a member the case is considered a member appeal or member grievance and is subject to the member appeal or grievance timeframes and policies.**

Aetna Better Health will inform providers through the Provider Manual and other mediums including newsletters, training, provider orientation, the website and by the provider calling their Provider Experience Representative about the provider dispute process.

Aetna Better Health's processes for resolving provider disputes, complaints, claim reconsiderations and appeals are described below.

Provider Disputes

Providers may file a dispute regarding any aspect of the health plan's administrative functions, policies, procedures, or concerns regarding the payment of a claim. Provider disputes regarding administrative issues are received, researched, and reviewed within the Provider Experience department of Aetna Better Health. Provider disputes related to claim payment issues are delegated to Claims Inquiry /Claims Research (CICR) for analysis and research. Aetna Better Health will notify the provider of its decision by phone, email, fax, or postal mail.

The Provider may be required to complete and submit the Provider Dispute Form and any appropriate supporting documentation to designated department listed on the form. The Provider Dispute Form is accessible on Aetna Better Health's website, via fax or by mail.

The Provider Experience Manager assigns the Dispute Form to a Provider Experience Representative to research, analyze, and resolve. In the event of a claim dispute, it is delegated to Claims Inquiry Claims Research (CICR) to research, analyze, and review. Aetna Better Health will mail its written notice of its decision to the Provider. Requests for claim resubmissions including reconsideration or corrections that are received with a supporting claim at the health plan are forwarded to the plan specific claims Post Office (P.O.) Box for claims processing.

Rendering providers have the ability to submit a dispute for those provider claims or group of claims that have been denied or underpaid within one hundred eighty (180) calendar days of the notice of the payment notification.

- Disputing a claim payment or denial based on a fee schedule or contractual issue
- Disputing a claim payment or denial based on a coding issue
- Any other reason for billing disputes

Note: Provider payment disputes do not include disputes related to medical necessity.

Providers can file a verbal dispute with Aetna Better Health of Louisiana by calling Provider Experience Department at **1-855-242-0802**.

To file a reconsideration in writing, providers must complete the provider claims reconsideration/dispute form (located on our public website) and mail to:

Aetna Better Health of Louisiana
P.O. Box 982962
El Paso, TX 79998-2962
Attn: Cost Containment

In the event the Provider remains dissatisfied with the dispute determination, the Provider is notified via a written notice. If the provider is not satisfied with the resolution of the dispute, the provider may be initiate a complaint.

Aetna Better Health's Provider Experience Representatives are available to discuss a Provider's dissatisfaction of an issue covered by this policy, and if unable to satisfy the Provider's dispute, the Provider Complaint Process will be offered.

Providers may file a provider dispute by:

- Calling Provider Experience at **1-855-242-0802**
- Faxing Provider Experience at **860-607-7658**
- Emailing Provider Experience at **LAProvider@aetna.com**
- Completing a Participating Provider Claims Reconsideration/Dispute Form and mailing it to:
  Aetna Better Health of Louisiana
  P.O. Box 982962
  El Paso, TX 79998-2962
  Cost Containment

Provider Complaints

In the event a provider remains dissatisfied with the dispute determination, the provider may file a written complaint, called a grievance or a verbal complaint. Providers may also file complaints including but not limited issues related to health plan staff, contracted vendors, or formulary.

Providers are allowed thirty (30) days from the date of the occurrence to file a written complaint with Aetna Better Health. An acknowledgement letter will be sent within three (3) business days summarizing the complaint and will include instruction on how to:

- Revise the complaint within the timeframe specified in the acknowledgement letter
- Withdraw a complaint at any time until Complaint Committee review

If the complaint requires research or input by another department, the Complaint System manager will forward the information to the affected department and coordinate with the affected department to thoroughly research each

complaint using applicable statutory, regulatory, and contractual provisions and Aetna Better Health's written policies and procedures, collecting pertinent facts from all parties.

The provider is offered a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing.

The complaint with all research will be presented to the Complaint Committee for decision. The Complaint Committee will include a provider with same or similar specialty if the complaint is related to a clinical issue. The Complaint Committee will consider the additional information and will resolve the complaint. A decision will be made within 30 calendar days of receipt and the provider will be notified in writing within 3 business days of the resolution.

Providers may file a provider complaint by:

- Calling Provider Experience at **1-855-242-0802**
- Faxing Appeals and Complaint Department at **860-607-7657**
- Emailing Appeals and Complaint at **LAAppealsandGrievances@aetna.com**
- In writing at:

  Aetna Better Health of Louisiana
  Appeal and Grievance Department
  P.O. BOX 81040
  5801 Postal Rd
  Cleveland, OH 44181

A trained and qualified Appeals and Grievance Manager assumes primary responsibility for coordinating and managing Provider complaints, and for disseminating information to the Provider about the status of the complaint.

Provider Claim Reconsiderations and Appeals

Providers may file a claim reconsideration or appeal with Aetna Better Health if a medical procedure or item performed or given to an Aetna Better Health member has been denied reimbursement due to lack of medical necessity or no prior authorization when an authorization was required. A provider may also file a claim reconsideration or appeal, if they have a claim that has been denied or paid differently than expected and was not resolved to the provider's satisfaction through the dispute process. Filing a claim reconsideration or appeal will not negatively affect or impact the Aetna Better Health member or providers who treat the member.

Aetna Better Health will confirm that the individual(s) who make decisions on appeals and claim reconsiderations either individually or through Appeal Committee are individual(s) who were not involved in any previous level of review or decision-making and if deciding an appeal or claim reconsideration of a denial, reduction, termination or suspension that is based on lack of medical necessity or an appeal or claim reconsideration that involves other clinical issues are health care professionals with same or similar specialty who have the appropriate training and clinical expertise, as determined by the state agency, in the field of medicine treating the member's condition or disease or who has experience treating the member's condition or disease or treating similar complications related to the member's condition or disease.

Providers requesting to file an expedited appeal for a prior authorization denial and have not yet rendered services will be transferred to the Expedited Member Appeals process defined in the Members section of this document.

Expedited requests do need written member consent for the provider to act on behalf of the member and they must meet expedited criteria, that waiting the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

The claim reconsideration is the first step of the appeal process. Provider claim reconsiderations and appeals will be reviewed and resolved within thirty (30) calendar days of receipt. An acknowledgement letter will be sent within five (5) calendar days of receipt and will include instruction on how to:

- Revise the appeal or claim reconsideration within the timeframe specified in the acknowledgement letter
- Withdraw an appeal or claim reconsideration at any time until Appeal Committee review

Providers or their authorized representative may submit a claim reconsideration request verbally in or writing within one hundred eighty (180) calendar days of the Remittance Advice paid date.

A provider's request for claim reconsideration is required before requesting a provider claim appeal. Providers or their authorized representative have the option to submit an appeal following the claim reconsideration process. The provider must submit any documentation from the claim reconsideration request when submitting a provider appeal.

Providers can submit an appeal request in writing within ninety (90) calendar days from the date of the Claim Reconsideration Decision Letter from the original request for claim reconsideration.

Additional or new clinical documents sent to Aetna Better Health will be reviewed by the medical director to re-determine if the additional or new clinical documents will support the claim reconsideration or appeal in meeting medical necessity.

A resolution letter will be mailed within thirty (30) calendar days from receipt of the appeal or claim reconsideration and the provider will be notified in writing within three (3) business days of the resolution.

Providers may file a claim reconsideration or provider appeal by:

- Calling Provider Experience at **1-855-242-0802**
- Faxing the Appeals and Grievance Manager at **860-607-7657**
- Emailing the Appeals and Grievance Manager at **LAAppealsandGrievances@aetna.com**
- Writing Aetna Better Health at:

  Aetna Better Health of Louisiana
  Appeal and Grievances Department
  P.O. BOX 81040
  5801 Postal Rd
  Cleveland, OH 44181

Independent Review

The Independent Review process was established to resolve claims disputes when a provider believes the health plan has partially or totally denied claims incorrectly. Independent Review is a two (2) step process which may be initiated by submitting an Independent Review Reconsideration form to Aetna Better Health within one hundred eighty (180) calendar days of the Remittance Advice paid, denial, or recoupment date.

The types of claims eligible for independent review are as follows:

- Claims billed to Aetna Better Health after January 1, 2018.
- Claims denied in whole or in part by Aetna Better Health.
- Claims where Aetna Better Health recouped monies remitted for a previously paid claim.
- Claims where the provider did not receive a notice from Aetna Better Health either partially or totally denying the claim.
- Claims where Aetna Better Health recouped monies from a mental health rehabilitation service provider as a result of a finding of waste or fraud.
- Claims involved in arbitration or litigation **cannot** be sent to independent review.

<u>Step 1 – Independent Review Reconsideration (IRR)</u>

An IRR may be initiated by submitting an Independent Review Reconsideration Request Form to Aetna Better Health within one hundred eighty (180) calendar days of the Remittance Advice paid, denial, or recoupment date. Prior to submitting an independent review to LDH, the provider must submit a request for independent review reconsideration (IRR) to Aetna Better Health within one hundred eighty (180) days from one of the following dates:

- Date on which Aetna Better Health transmits remittance advice or other notice of claim denial.
- Sixty (60) days from the date the claim was submitted to Aetna Better Health if the provider receives no notice from Aetna Better Health either partially or totally denying the claim.

- Date on which Aetna Better Health recoups monies remitted for a previously paid claim.

Aetna Better Health will acknowledge in writing its receipt of the IRR request within five (5) calendar days after receipt of the request.

Aetna Better Health renders a final decision of the IRR request within forty-five (45) calendar days from the date of receipt, unless another time frame is agreed upon in writing by the provider and Aetna Better Health.

IRR Request forms can be found on the Aetna Better Health of Louisiana website, or on the LDH websites below:
- https://www.aetnabetterhealth.com/louisiana/providers/index.html
- http://ldh.la.gov/assets/HealthyLa/IndependentReview/IRRForm.pdf

The completed request form along with all required documents should be sent via mail or email to the following:

(Preferred method) Email: Independentreviewrequest@aetna.com
Aetna Better Health of Louisiana
Attn: Independent Review Reconsideration
P.O. Box 81040
5801 Postal Rd
Cleveland, OH 44181

If for some reason an IRR form is not used, the IRR request must clearly state that it is a request for independent review reconsideration.

Step 2 –Independent Review with LDH (IRO)

If Aetna Better Health upholds the adverse determination or does not respond to the IRR request within the forty-five (45) calendar days allowed, the provider may then submit the independent review to LDH.
- LDH must receive the independent review request within either:
  - Sixty (60) days of the date the provider received Aetna Better Health's decision of the IRR request; or
  - If the provider does not receive a decision within the forty-five (45) calendar day time frame, sixty (60) days from the last day of the time frame or one hundred five (105) days from the date the IRR request was submitted to Aetna Better Health.

To submit a request for independent review, the provider must complete the LDH Independent Review Request form. The form can be found here: **https://ldh.la.gov/page/2982**

The completed request form along with all required documents (listed on the form) should be sent via certified mail to LDH at the following address:

LDH/Health Plan Management
P.O. Box 91030, Bin 24
Baton Rouge, LA 70821-9283
Attn: Independent Review

Provider Arbitration

Provider has the option to request binding arbitration for claims that have denied or underpaid claims or a group of claims bundled, by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If Company and Provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his/her certifying association. Arbitration conducted pursuant to this Section shall be binding on all Parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) days of being selected unless Company and Provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the Parties. [RFP § 17.6.5]. A provider should review their contract with ABH for any specific language related to arbitration.

State Fair Hearing (only member has the right to request for SFH)

Providers may ask for a State Fair Hearing on behalf of the member, with the member's permission and signed consent form from Louisiana Department of Health (LDH) within one hundred twenty (120) days of the date we sent your appeal decision letter. The Louisiana Division of Administrative Law makes a recommendation about your hearing to the Secretary of LDH. The Secretary of LDH makes the final decision about your appeal.

You can file a State Fair Hearing request by phone, fax, mail or on the web. Mail: P.O. Box 4189 Baton Rouge, Louisiana 70821-4189 Fax: **225-219-9823** Phone: **225-342-5800** Web: **www.adminlaw.state.la.us/HH.htm**

LDH Dispute Process

In the event a provider remains dissatisfied with their claim dispute or complaint determination or they are unable to get a timely response from Aetna Better Health, the provider may file a dispute directly to LDH. There are also specific circumstances when the issue in dispute should be handled by LDH, such as a request for coverage for an item or service that is not covered under the benefit plan. For example, the request for coverage of a specialized behavioral health service that is covered by a separate behavioral plan. In the case of a benefit, that is not a unique covered benefit of Aetna Better Health of Louisiana; the provider can file a dispute directly to LDH. For issues where the provider remains unsatisfied or the issue is identified as an LDH responsibility, Provider Experience will provide education to the provider on their right to dispute through LDH. To contact LDH:

- E-mail LDH staff at **ProviderRelations@la.gov**. Be sure to include details on attempts to resolve the issue at the Health Plan level as well as contact information (contact name, provider name, e-mail, and phone number) so that Healthy Louisiana staff can follow up with any questions.

LDH often posts news, informational bulletins, and frequently asked questions to address systemic or trending provider issues. Providers can subscribe to updates from Healthy Louisiana to be notified of any newsletter or informational bulletin postings, and providers are encouraged to visit the provider portal at **www.Medicaid.LA.gov** for the latest provider news and information.

Oversight of the Appeal and Grievance Processes

The Appeal and Grievance Manager has overall responsibility for management of the Appeal and Grievance processes and reports to the Director of Operations. This includes:

- Documenting individual appeals and grievances
- Coordinating resolutions
- Maintaining the data for all appeals and grievances in the Appeal and Grievance Application
- Tracking and reviewing grievance and appeal data for trends in quality of care or other service-related issues
- Reporting all data to the Service Improvement Committee (SIC) and Quality Management Oversight Committee (QMOC)

Aetna Better Health's grievance and appeals processes are integrated into our quality improvement program. Our Quality Management (QM) responsibility of the grievance system processes includes:

- Review of individual quality of care grievances
- Aggregation and analysis of grievance and appeal trend data
- Use of the data for quality improvement activities including collaboration with credentialing and recredentialing processes as required
- Identification of opportunities for improvement
- Recommendation and implementation of corrective action plans as needed

This makes sure that individuals with the authority to take corrective action are actively engaged in the appeal and grievance process and that data received through member and provider appeals and grievances are routinely reviewed to identify opportunities for improvement and to apply continuous quality improvement principles.

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Fraud, Waste and Abuse

Aetna Better Health of Louisiana has an aggressive, proactive fraud, waste, and abuse program that complies with state and federal regulations. Our program targets areas of healthcare related fraud and abuse including internal fraud, electronic data processing fraud and external fraud. A Special Investigations Unit (SIU) is a key element of the program. This SIU detects, investigates, and reports any suspected or confirmed cases of fraud, waste or waste to appropriate State and federal agencies as mandated by Louisiana Administrative Code. During the investigation process, the confidentiality of the patient and people referring the potential fraud and abuse case is maintained.

Aetna Better Health of Louisiana uses a variety of mechanisms to detect potential fraud, waste, and abuse. All key functions including Claims, Provider Experience, Member Services, Medical Management, as well as providers and members, shares the responsibility to detect and report fraud. Review mechanisms include audits, review of provider service patterns, hotline reporting, claim review, data validation, and data analysis.

Special Investigations Unit (SIU)

Our Special Investigations Unit (SIU) conducts proactive monitoring to detect potential fraud, waste, and abuse, and in responsible to investigate cases of alleged fraud, waste, and abuse. With a total staff of approximately 100 individuals, the SIU is comprised of experienced, full-time investigators: field fraud (claims) analysts; a full-time, a dedicated information technology organization; and supporting management and administrative staff.

The SIU has a national toll-free fraud hotline for providers who may have questions, seek information, or want to report potential fraud, waste, or abuse. The number is **1-800-338-6361**. The hotline has proven to be an effective tool, and Aetna Better Health of Louisiana encourages providers and contractors to use it.

To achieve its program integrity objectives, the SIU has state-of-the-art technology and systems capable of monitoring Aetna's huge volume of claims data across health product lines. To help prevent fraud, it uses advanced business intelligence software to identify providers whose billing, treatment, or member demographic profiles differ significantly from those of their peers. If it identifies a case of suspected fraud, the SIU's Information Technology and investigative professionals collaborate closely both internally with the compliance department and externally with law enforcement as appropriate, to conduct in-depth analyses of case-related data.

Reporting Suspected Fraud and Abuse

Participating providers are required to report to Aetna Better Health of Louisiana all cases of suspected fraud, waste and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

Providers can report suspected fraud, waste, or abuse in the following ways:

- By phone to the confidential Aetna Better Health of Louisiana Compliance Hotline at **1-855-725-0288**
- By phone to our confidential Special Investigation Unit (SIU) at **1-800-338-6361**

Note*:* If you provide your contact information, your identity will be kept confidential.

You can also report provider fraud to LDH, at **1-800-488-2917** or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services at **1-800-HHS-TIPS** (**1-800-447-8477**).
(**http://LDH.state.la.us/index.cfm/page/219**)

The Louisiana Department of Health Program Integrity Unit was created by statute to preserve the integrity of the Medicaid program by conducting and coordinating Fraud, Waste, and Abuse control activities for all State agencies responsible for services funded by Medicaid.

A provider's best practice for preventing fraud, waste, and abuse (also applies to laboratories as mandated by 42 C.F.R. 493) is to:

- Develop a compliance program
- Monitor claims for accuracy - verify coding reflects services provided
- Monitor medical records – verify documentation supports services rendered
- Perform regular internal audits
- Establish effective lines of communication with colleagues and members
- Ask about potential compliance issues in exit interviews
- Take action if you identify a problem
- Remember that you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim.

Fraud, Waste, and Abuse Defined

- **Fraud**: an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.
- **Waste**: over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.
- **Abuse**: means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Examples of Fraud, Waste, and Abuse

Examples of Fraud, Waste, and Abuse include:

- Charging in excess for services or supplier
- Providing medically unnecessary services
- Billing for items or services that should not be paid for by Medicaid
- Billing for services that were never rendered
- Billing for services at a higher rate than is actually justified
- Misrepresenting services resulting in unnecessary cost to Aetna Better Health of Louisiana due to improper payments to providers, or overpayments
- Physical or sexual abuse of members

Fraud, Waste, and Abuse can incur risk to providers:

- Participating in illegal remuneration schemes, such as selling prescriptions
- Switching a member's prescription based on illegal inducements rather than based on clinical needs.
- Writing prescriptions for drugs that are not medically necessary, often in mass quantities, and often for individuals that are not patients of a provider
- Theft of a prescriber's Drug Enforcement Agency (DEA) number, prescription pad, or e-prescribing login information
- Falsifying information in order to justify coverage
- Failing to provide medically necessary services
- Offering members, a cash payment as an inducement to enroll in a specific plan
- Selecting or denying members based on their illness profile or other discriminating factors.
- Making inappropriate formulary decisions in which costs take priority over criteria such as clinical efficacy and appropriateness.
- Altering claim forms, electronic claim records, medical documentation, etc.
- Limiting access to needed services (for example, by not referring a member to an appropriate provider).
- Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for a referral in exchange for the ordering of diagnostic tests and other services or medical equipment).
- Billing for services not rendered or supplies not provided would include billing for appointments the members fail to keep. Another example is a "multi patient" in which a provider visits a nursing home billing for twenty (20) nursing home visits without furnishing any specific service to the members.

- Double billing such as billing both Aetna Better Health of Louisiana and the member, or billing Aetna Better Health of Louisiana and another member.
- Misrepresenting the date services were rendered or the identity of the member who received the services.
- Misrepresenting who rendered the service, or billing for a covered service rather than the non-covered service that was rendered.

Fraud, Waste and Abuse can incur risk to members as well:

- Unnecessary procedures may cause injury or death
- Falsely billed procedures create an erroneous record of the member's medical history.
- Diluted or substituted drugs may render treatment ineffective or expose the member to harmful side effects or drug interactions.
- Prescription narcotics on the illegal market contribute to drug use and addition.

In addition, member fraud is also reportable, and examples include:

- Falsifying identity, eligibility, or medical condition in order to illegally receive the drug benefit
- Attempting to use a member ID card to obtain prescriptions when the member is no longer covered under the drug benefit
- Looping (i.e., arranging for a continuation of services under another member's ID)
- Forging and altering prescriptions.
- Doctor shopping (i.e., when a member consults a number of doctors for obtaining multiple prescriptions for narcotic painkillers or other drugs Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the illegal market.

FWA Audits

When post payment audits are complete with findings, SIU will issue an overpayment letter detailing the results of the review. This letter will include a statement regarding the provider's opportunity to rebut the findings.

The provider will contact the SIU within 15 days. The SIU will instruct the provider to submit any details, additional documents, or reference material in writing.

The provider may also request a peer-to-peer review with the medical directors / clinical review team. The SIU will coordinate this meeting and include the appropriate personnel requested by the provider, SIU, and the health plan.

The provider will be notified of the outcome of the rebuttal. If the provider continues to dispute the findings, the next steps in their appeal process will be based on the guidelines in the appeals and grievances outlined in **Grievance System.**

FWA Prepayment Review

One of the tools used by the SIU to identify potential fraud, waste and abuse is prepayment review. Providers identified for billing irregularities, aberrances to their peers, possible service not rendered, etc. might be placed on prepayment review. Provider's will be notified in a letter explaining their claims will require medical records prior to payment by the MCO. This notification will include the reason for the prepayment review along with instructions on what medical records are required and where they should be sent. The letter also includes information regarding the providers right to appeal a claim denial after the documentation is reviewed.

Elements to a Compliance Plan

An effective Compliance Plan includes seven core elements:

1. Written Standards of Conduct: Development and distribution of written policies and procedures that promote Aetna Better Health of Louisiana's commitment to compliance and that address specific areas of potential fraud, waste, and abuse.
2. Designation of a Compliance Officer: Designation of an individual and a committee charged with the responsibility and authority of operating and monitoring the compliance program.
3. Effective Compliance Training: Development and implementation of regular, effective education, and training

4. Internal Monitoring and Auditing: Use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem area.
5. Disciplinary Mechanisms: Policies to consistently enforce standards and addresses dealing with individuals or entities that are excluded from participating in the Medicaid program.
6. Effective Lines of Communication: Between the Compliance Officer and the organization's employees, managers, and directors and members of the compliance committee, as well as related entities
    a. Includes a system to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance, will maintaining confidentiality.
    b. Related entities must report compliance concerns and suspected or actual misconduct involving Aetna Better Health of Louisiana.
7. Procedures for responding to Detected Offenses and Corrective Action: Policies to respond to and initiate corrective action to prevent similar offenses including a timely, responsible inquiry.

Relevant Laws

There are several relevant laws that apply to Fraud, Waste, and Abuse:

- The Federal False Claims Act (FCA) (31 U.S.C. §§ 3729-3733) was created to combat fraud & abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. Penalties can include up to three times actual damages and an additional $5,500 to $11,000 per false claim. The False Claims Act prohibits, among other things:
    - Knowingly presenting a false or fraudulent claim for payment or approval
    - Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government
    - Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid

  "Knowingly" means that a person, with respect to information: 1) has actual knowledge of the information; 2) acts in deliberate ignorance of the truth or falsity of the information; 3) acts in reckless disregard of the truth or falsity of the information.

  Providers contracted with Aetna Better Health of Louisiana must agree to be bound by and comply with all applicable State and federal laws and regulations.

- Anti-Kickback Statute
    - The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a federal health care program. Remuneration includes anything of value, directly or indirectly, overtly, or covertly, in cash or in kind.

- Self-Referral Prohibition Statute (Stark Law)
    - Prohibits providers from referring members to an entity with which the provider or provider's immediate family member has a financial relationship unless an exception applies.

- Red Flag Rule (Identity Theft Protection)
    - Requires "creditors" to implement programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft.

- Health Insurance Portability and Accountability Act (HIPAA) requires:
    - Transaction standards
    - Minimum security requirements
    - Minimum privacy protections for protected health information
    - National Provider Identification (NPIs) numbers

- The Federal Program Fraud Civil Remedies Act (PFCRA), codified at 31 U.S.C. §§ 3801-3812, provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are $5,500 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the government makes a payment. The amount of the false claim's penalty is to be adjusted periodically for inflation in accordance with a federal formula.

- Under the Federal Anti-Kickback statute (AKA), codified at 42 U.S.C. § 1320a-7b, it is illegal to knowingly and willfully solicit or receive anything of value directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual or ordering or arranging for any good or service for which payment may be made in whole or in part under a federal health care program, including programs for children and families accessing Aetna Better Health of Louisiana services through Healthy Louisiana.

- Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. § 1396a(a)(68), Aetna Better Health of Louisiana providers will follow federal and State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs, including programs for children and families accessing Aetna Better Health of Louisiana services through Healthy Louisiana.

- The Louisiana False Claims Act (LAFCA), otherwise known as the Medical Assistance Programs Integrity Law (MAPIL) , Chapter RS 46:437.1, which was enacted in 1996 intends the secretary of the Louisiana Department of Health, Attorney General and whistleblowers to be agents of the state with the ability, authority and resources to pursue civil monetary penalties, liquidating damages, or other remedies to protect the fiscal and programmatic integrity of the medical assistance programs from health care providers and other persons who engage in fraud, misrepresentation, abuse, or other ill practices, as set forth herein, to obtain payments to which these health care providers or persons are not entitled. RS 46:437.1, 1997, No.1373, §1

- Under the criminal provisions of the Louisiana Medical Assistance Programs Assistance Integrity Law (MAPIL), codified at RS 46:437.1, 1997, No.1373, §1., providers with Aetna Better Health of Louisiana will refrain from engaging in fraud or other criminal violations relating to Title XIX (Medicaid)-funded programs. Prohibited conduct includes but is not limited to: (a) fraudulent receipt of payments or benefits; (b) false claims, statements or omissions, or conversion of benefits or payments; (c) kickbacks, rebates, and bribes; and (d) false statements or representations about conditions or operations of an institution or facility to qualify for payments. Providers engaging in criminal violations may be excluded from participation in Medicaid and other health care programs under RS 46:437.1, 1997, No.1373, §1

- Under the civil provisions of the MAPIL, codified at RS 46:438.6, providers with Aetna Better Health of Louisiana: (1) will repay with interest any amounts received as a result of unintentional violations; and (2) are liable to pay up to triple damages and (as a result of the Louisiana False Claims Act) between $5,500 and $11,000 per false claim when violations of the Medicaid statute are intentional, or when there is a violation of the Louisiana False Claims Act. Providers engaging in civil violations may be excluded from participation in Medicaid and other health care programs under RS 46:437.14

- Under the Medical Assistance Programs Assistance Integrity Law (MAPIL), codified at RS 46:438.3, licensed providers are prohibited from engaging in conduct that amounts to, "dishonesty, fraud, deception, misrepresentation, false promise, or false pretense" or involves false or fraudulent advertising

- Under the Medical Assistance Programs Assistance Integrity Law (MAPIL), codified at RS 46:440.3,Whistleblower Protection and Cause of Action., provider agencies are prohibited from taking retaliatory action against employees who: (a) disclose or threaten to disclose to a supervisor or any public agency an activity, policy or practice of the provider agency or another business with which the provider agency shares a business relationship, that the employee reasonably believes to be illegal, fraudulent and criminal; (b) provides information or testimony to any public agency conducting an investigation, hearing or inquiry into any violation of law, rule or regulation by the provider agency or another business with which the

provider agency shares a business relationship; or (c) objects to, or refuses to participate in any activity, policy or practice which the employee reasonably believes is illegal, fraudulent, criminal or incompatible with a clear mandate of public policy concerning the public health, safety or welfare, or protection of the environment.

- Office of the Inspector General (OIG) and General Services Administration (GSA) Exclusion Program Prohibits identified entities and providers excluded by the OIG or GSA from conducting business or receiving payment from any Federal health care program.

Administrative Sanctions

Administrative sanctions can be imposed, as follows:

- Denial or revocation of Medicare or Medicaid provider number application (if applicable)
- Suspension of provider payments
- Being added to the OIG List of Excluded Individuals/Entities database
- License suspension or revocation

Remediation

Remediation may include any or all of the following:

- Education
- Administrative sanctions
- Civil litigation and settlements
- Criminal prosecution
    - Automatic disbarment
    - Prison time

Additional Resources

- **www.legis.state.la.us/lss/lss.asp?doc=100852&showback=**
- **www.LDH.state.la.us/index.cfm/page/219**
- **www.LDH.state.la.us/index.cfm/form/22**

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Mandated Reporters

As mandated by Louisiana Administrative Code and Louisiana Statues Annotated (RS 14:403.2), all providers who work or have any contact with an Aetna Better Health of Louisiana member, are required as "mandated reporters" to report any suspected incidences of physical abuse (domestic violence), neglect, mistreatment, financial exploitation and any other form of maltreatment of a member to the appropriate state agency. A full version of the Louisiana Administrative Code can be found on the State of Louisiana Office of Administrative Law website at **www.doa.la.gov/Pages/osr/lac/Code.aspx**.

Children

Providers must report suspected or known child abuse, and neglect to the Department of Child and Family Services (DCFS) (**1-855-452-5437**) or law enforcement agency where the child resides. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child's welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

Vulnerable Adults

Providers must report suspected or known physical abuse (domestic violence), neglect, maltreatment, and financial exploitation of a vulnerable adult immediately to one of the following State agencies:

- The National Domestic Violence Hotline at **1-800-799-SAFE (7233)**
- Reporting Agencies
  - Adult/Elderly Protection Services – **1-800-898-4910**
  - Intermediate Care Facility for Developmentally Disabled - complaints – **1-877-343-5179**
  - Home Health – **1-800-327-3419**
  - Nursing Home – **1-888-810-1819**
  - Support Coordination (Case Management) – **1-800-660-0488**
  - Home & Community Based Service Provider (HCBS) – **1-800-660-0488**

For members living in a nursing home or ICF/DD, providers must report incidences via the Online Tracking Incident System (OTIS)

- **www.LDH.state.la.us/index.cfm/page/280**

State law provides immunity from any criminal or civil liability because of good faith reports of child abuse or neglect. Any person who knowingly fails to report suspected abuse or neglect may be subject to a fine up to $1,000 or imprisonment up to six months.

Reporting Identifying Information

Any provider who suspects that a member may be in need of protective services should contact the appropriate State agencies with the following identifying information:

- Names, birth dates (or approximate ages), race, genders, etc.
- Addresses for all victims and perpetrators, including current location
- Information about family members or caretakers if available
- Specific information about the abusive incident or the circumstances contributing to risk of harm (e.g., when the incident occurred, the extent of the injuries, how the member says it happened, and any other pertinent information)

After reporting the incident, concern, issue, or complaint to the appropriate agency, the provider office must notify Aetna Better Health of Louisiana's Compliance Hotline at **1-855-725-0288.**

Our providers must fully cooperate with the investigating agency and will make related information, records and reports available to the investigating agency unless such disclosure violates the federal Family Educational Rights and Privacy Act (20 U.S.C. § 1232g).

Examinations to Determine Abuse or Neglect

When a state agency notifies Aetna Better Health of Louisiana of a potential case of neglect and abuse of a member, our case managers will work with the agency and the Primary Care Provider (PCP) to help the member receive timely physical examinations for determination of abuse or neglect. In addition, Aetna Better Health of Louisiana also notifies the appropriate regulatory agency of the report.

Depending on the situation, Aetna Better Health of Louisiana case managers will provide member with information about shelters and domestic violence assistance programs along with providing verbal support.

Examples, Behaviors and Signs

Abuse

Examples of Abuse:

- Bruises (old and new)
- Burns or bites
- Pressure ulcers (Bed sores)
- Missing teeth
- Broken bones/Sprains
- Spotty balding from pulled hair
- Marks from restraints
- Domestic violence

Behavior Indicators of a Child Wary of Adult Contacts:

- Apprehensive when other children cry
- Behavioral extremes
- Aggressiveness
- Withdrawal
- Frightened of parents
- Afraid to go home
- Reports injury by parents

Behaviors of Abusers (Caregiver and/or Family Member):

- Refusal to follow directions
- Speaks for the patient
- Unwelcoming or uncooperative attitude
- Working under the influence
- Aggressive behavior

Neglect

Types of Neglect:

- The intentional withholding of basic necessities and care
- Not providing basic necessities and care because of lack of experience, information, or ability

Signs of Neglect:

- Malnutrition or dehydration
- Un-kept appearance; dirty or inadequate
- Untreated medical condition
- Unattended for long periods or having physical movements unduly restricted

Examples of Neglect:

- Inadequate provision of food, clothing, or shelter
- Failure to attend health and personal care responsibilities, such as washing, dressing, and bodily functions

Financial Exploitation

Examples of Financial Exploitation:

- Caregiver, family member, or professional expresses excessive interest in the amount of money being spent on the member
- Forcing member to give away property or possessions
- Forcing member to change a will or sign over control of assets

Pharmacy Management Overview

Aetna Better Health of Louisiana covers prescription medications and certain over-the-counter medicines for members enrolled in a plan with Pharmacy Benefits. The Pharmacy Benefit is administered through Prime Therapeutics. Prime Therapeutics is responsible for pharmacy network contracting and network Point-of-Sale (POS) claim processing. Aetna Better Health of Louisiana follows the state's Single Preferred Drug List (SPDL), drug utilization review, and prior authorization criteria. For a list of preferred drugs listed within the therapeutic classes, please visit the state's website at https://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf or **AetnaBetterHealth.com/Louisiana,** under What's Covered, then Benefits Details, then Pharmacy and Prescription Drugs.

Pharmacy Benefits Manager (PBM)

Effective October 1, 2024, Prime Therapeutics will process all Louisiana Medicaid MCO pharmacy claims. The Prime Therapeutics pharmacy website is https://www.lamcopbmpharmacy.com/. Stakeholder presentations relating to project implementation can be found at https://ldh.la.gov/page/1328. With the implementation of the new single PBM, the following LDH policies will go into effect:

- LDH will add diabetic supplies to the Medicaid Single Preferred Drug List to have one list of preferred/non-preferred products. As of December 1, 2023, diabetic supplies are limited to pharmacy claims only.

Prime Therapeutics Pharmacy Call Center is available 24/7 at the contacts below. Pharmacy providers can contact the Prime Therapeutics Provider Contracting Department at rxnetworksdept@primetherapeutics.com to verify the pharmacy is contracted with Prime Therapeutics.

- Member and Pharmacy Help Desk Phone Number: 1-800-424-1664
- Pharmacy Prior Authorizations (PA) Phone Number: 1-800-424-1664
- Fax Number: 1-800-424-7402
- Electronic: Enter prescriber PA at **www.covermymeds.com**

Pharmacy processing information for all six Medicaid MCOs starting October 28, 2023:

- BIN Number: 025986
- NCPDP Version/Release #: D.0
- Processor Control #: 1214172240
- Group ID: LAMCOPBM

Prescriptions, Preferred Drugs and Specialty Injectables

The SPDL is a list of drugs reviewed by Louisiana Department of Health's Pharmacy P & T Committee and approved by the LDH Secretary. Drugs are listed as preferred and non-preferred. All non-preferred drugs are required to follow the prior authorization process. The list is also referred to as the Louisiana Medicaid Single PDL.

There is a subset of drugs not listed on the Louisiana Medicaid Single PDL which may be available for coverage. These drugs typically do not require prior authorization. Generic substitution is mandated by the state. Clinical edits, such as quantity limits and age restrictions, may apply to some drug categories.

Please review the Preferred Drug List for any restrictions or recommendations regarding prescription drugs before prescribing a medication to an Aetna Better Health of Louisiana patient.

Louisiana Medicaid Single PDL (Fee For Service and Managed Care Organizations)

Check the current SPDL before writing a prescription for either prescription or over-the-counter drugs. Pharmacy Prior Authorization forms are available on our website and requests may be made telephonically by contacting Prime Therapeutics at **1-800-424-1664.** Note: Aetna Better Health of Louisiana will cover non-preferred medications for members new to the plan for the first 60 days of enrollment if the member has been on the medication prior to enrolling and pharmacist or prescriber notifies the prior authorization team.

Aetna Better Health of Louisiana members must have their prescriptions filled at a network pharmacy.

Prior Authorization Process
ABHLA delegates the Prior Authorization Process to Prime Therapeutics. The PA process will support the most effective medication choices by addressing drug safety concerns, encouraging proper administration of the pharmacy benefit, and determining medical necessity. With the exception of excluded drug classes, medications that are not included in this PDL are almost always covered without the requirement of prior authorization. Medications listed as non-preferred are available through the PA process. Please see the LDH PDL for requirements.

The prescribing provider and member will be appropriately notified of all decisions in accordance with regulatory requirements. Prior to making a final decision, our Medical Director may contact the prescriber to discuss the case or consult with a board-certified physician from an appropriate specialty area such as a psychiatrist.

Aetna Better Health of Louisiana allows a pharmacy to fill prescriptions for a 72-hour supply if the member's prescription has not been filled due to a pending PA decision.

Brand Name and Generic Drugs
Claims for multi-source "Brand Name Products" that are not included in the PDL/NPDL process (i.e., drugs not listed on the Preferred Drug List on the static link), shall not be subject to prior authorization. Since the manufacturers of these brand name products have signed the federal rebate agreement, these drugs must have a potential payable status. In consideration of the mandatory generic substitution, LDH requires the MCOs/PBMs to allow dispense as written (DAW) codes "1", "5", "8", and "9" for brand name processing. LDH expects the following codes to accommodate the filling of a brand name product without use of prior authorization:

- DAW "1": Brand name medically necessary from prescriber.
- DAW "5": Substitution allowed-brand drug dispensed as a generic (should be allowed when the brand drug is less expensive for 340B providers).
- DAW "8": Substitution allowed; generic drug not available in marketplace.
- DAW "9": Preferred brand over generic drugs.

Denials of brand drugs (unless the brand is a preferred drug—in or out of the process) should deny with an error code stating, "generic substitution required," mapped to NCPDP 22 (M/I Dispense as written (DAW)/Product selection code).

Injectable Medications
When any portion of a single dose vial is used, providers may bill for the complete vial. Providers are expected to procure medication most closely matching dosages typically administered. Any attempt to maximize reimbursement are subject to recoupment and additional sanctions.

Total Parenteral Nutrition (TPN)
TPN is covered as a Pharmacy benefit. Associated supplies and equipment are covered services as Durable Medical Equipment (DME).

Diabetic Supplies
Effective with dates of service on or after 12/01/23, the following diabetic supplies and equipment will be reimbursed as a pharmacy benefit only:

- Diabetic glucose meters
- Diabetic test strips
- Continuous glucose meters
- Transmitters and sensors
- External insulin pumps
- Control solution
- Ketone test strips
- Lancets and devises
- Pen needles
- Reusable insulin pens

- Syringes

Diabetic test strips and lancets are subject to quantity limits. Preferred products and prior authorization criteria for continuous glucose monitors are posted on Diabetic Supplies Preferred Drug List at https://www.ldh.la.gov/assets/docs/BayouHealth/Pharmacy/PDL.Diabetic.Supplies.pdf . Reimbursement is based on the lower of:

6. The wholesale acquisition cost (WAC) plus the professional dispensing fee; or
7. The provider's usual customary charge to the general public.

Act 246: Revision of Schedule IV Controlled Dangerous Substance Drugs

Effective October 1, 2024, the state of Louisiana revised the list of Schedule IV controlled dangerous substance drugs to include Mifepristone and Misoprostol. In accordance, LDH issued a Memorandum and Guidance to aid in the use of Mifepristone and Misoprostol in Hospital Inpatient Settings. The Memorandum and Guidance can be viewed in its entirety, including the language of Act 246, at https://ldh.la.gov/assets/medicaid/LDH-Guidance-Act-246-La-Reg-Session-2024.pdf.

CHAPTER 22: PHYSICIAN ADMINISTERED DRUG PRICING AND MAXIMUM UNITS

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ABHLA is in alignment with the Louisiana Medicaid program for reimbursement of physician-administered drugs. Physician-administered drugs will align their maximum daily units with Federal Drug Administration (FDA) recommendations based on the following:

- Informational Bulletin (IB) 21-19 issued by the Louisiana Department of Health,
- Informational Bulletin (IB) 18-11 issued by the Louisiana Department of Health,
- Centers for Medicare & Medicaid Services (CMS) Average Sales Price (ASP) pricing file, and
- Food & Drug Administration (FDA) guidelines sited in Clinical Pharmacology, clinical resource.

Physician-administered drugs (such as J-code drugs) are those given by injection or infusion in a clinical setting and/or with the involvement of a healthcare provider, rather than self-administered by the patient. Aetna Better Health of Louisiana (ABHLA) covers physician-administered medications and their corresponding drug-related HCPCS codes in the following settings:

Hospital Outpatient

Drugs in this setting are billed on form UB-04 and are reimbursed at Cost-to-Charge Ratio (CCR) based on the following:

- Maximum daily unit for the drug, and
- Capped at ASP + 6%
- Drugs not included in the CMS file – one of the following methods:
  - If available, the wholesale acquisition cost (WAC) of the drug.
  - If no WAC is available, the reimbursement rate is 100 percent of the provider's current invoice for the dosage administered.

Infusion Pharmacies

Drugs in this setting are reimbursed at their maximum daily units and at one of the following methods:

- Drugs included in the CMS pricing file – ASP + 6%
- Drugs not included in the CMS file – one of the following methods:
  - If available, the wholesale acquisition cost (WAC) of the drug.
  - If no WAC is available, the reimbursement rate is 100 percent of the provider's current invoice for the dosage administered.

Prior Authorization (PA) is required for some physician-administered drugs, regardless of setting. Additionally, these drugs must be deemed medically necessary, and their administration must be within the scope of the provider's practice.

> **TIP:** To determine drug authorization requirements, use the prior authorization lookup tool, ProPAT, at **https://medicaidportal.aetna.com/propat/Default.aspx**.

The following forms will be available online at **www.aetnabetterhealth.com/louisiana/providers/materials-forms.html**.

- **Abortion Certification of Informed Consent Form**
  To be completed by the provider attesting to the need for an abortion based on the criteria indicated in the form.

- **Consent to Sterilization**
  Consent to sterilization must be signed by both the enrollee and the provider performing the sterilization.

- **Acknowledgment of Hysterectomy Information**
  An acknowledgment of information provided related to hysterectomy to be signed by both the enrollee and provider.

- **Provider Claims Dispute Form**
  To be completed by a provider who needs to file a claim dispute.

- **Pharmacy Coverage Determination Request Form**

Each provider who contracts with a Healthy Louisiana Plan to furnish services to the members will be assured of the following rights:

- A Health Care Professional, acting within the lawful scope of practice, will not be prohibited from advising or advocating on behalf of a member who is his/her patient, for the following:
  - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
  - Any information the member needs in order to decide among all relevant treatment options.
  - The risks, benefits, and consequences of treatment or non-treatment.
  - The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- To receive information on the Grievance, Appeal and State Fair Hearing procedures.
- To have access to the Healthy Louisiana Plan's policies and procedures covering the authorization of services.
- To be notified of any decision by the Healthy Louisiana Plan to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
- To challenge, at the request of the Medicaid/CHIP member on their behalf, the denial of coverage of, or payment for, medical assistance.
- The Healthy Louisiana Plan's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- To be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification.

Public Records Request Protocol

LDH and MCOs (including Aetna Better Health of Louisiana) agree that timely responding to public records act requests ("PRR") is an important facet of the LDH/MCO relationship. These protocols are designed to facilitate a collaborative approach aimed at allowing LDH to promptly respond to these requests in accordance with law. PRRs may be presented that call for responses, and effort to create these responses, that range from simple to complicated. LDH and MCOs agree that collaborative cooperation founded upon early and frequent communications between both sides can be helpful.

These communications could serve to refine a request to the necessary records and to promote accurate responses. Such discussions are especially useful when such requests appear to be large, to be vague or confusing, seek information that does not exist as requested, or present other challenges that could impact response times. LDH and MCOs shall utilize these Protocols to produce streamlined, accurate and timely responses to PRRs.

Receipt of Potential Public Records Request

When LDH receives a request that may be a PRR, the Department will initiate contact with the MCO(s) that may have documents potentially responsive to the request. This will provoke a dialogue between the LDH legal team and MCO legal representatives where questions concerning the Request and potential responses can be addressed. The Parties agree to early and frequent communications regarding PRRs. These discussions would also allow for questions as to whether the document being sought may in fact be a public record.

Public Records' Requests Points of Contact for LDH and MCOs

The MCO shall provide LDH with the name of the individual who will serve as the point of contact for handling public records' requests within seven calendar days of request. If this point of contact changes at any time, the MCO shall provide LDH with an updated contact immediately.

LDH's point of contact for handling MCO-related public records' requests is the Medicaid Public Records Request Coordinator.

Transmission of the Public Records Request

Upon receipt of a PRR, LDH will determine if the response requires records from the MCO. If LDH believes the MCO has records responsive to a PRR, LDH shall notify the MCO of the PRR, and shall forward an exact copy of the request in its entirety via email to the MCO's point of contact for handling public records' requests within one business day of receipt.

If the MCO receives a public records' request directly from a requesting party, the MCO shall forward the request via email to the Medicaid Public Records Request Coordinator within one business day of receipt.

In no event shall the MCO directly respond to the requesting party to satisfy a PRR. Unless otherwise directed by a court of competent jurisdiction, LDH is the party that shall provide the response to each PRR.

If the MCO believes the records are not public and/or meet an exception to the Louisiana Public Records law, the MCO shall produce a log that describes each document or document type that is being withheld and shall describe the specific objection and legal basis for the withholding, pursuant to the timeline and in the requested format established by LDH. LDH and MCO agree that the MCO is only obligated to provide documents responsive to its Medicaid Managed Care product.

Process for LDH to Evaluate Whether Records are Subject to the Louisiana Public Records Law

Upon receipt of objection from MCOs, LDH and MCO shall confer at a mutually convenient time with due consideration to legal restraints for compliance with Public Records Law. LDH Legal will review the objections, and confer with the Medicaid Public Records Request Coordinator, as necessary, to address MCOs objections. LDH and MCO will confer regarding response to the PRR, including production of documents for which no objection is made, and alternative response, if possible, for records (e.g., redaction) for which objection is made.

Notice to MCOs of Impending Release of Records MCO has Deemed Not Public and/or Meet an Exception to the Public Records Law

If LDH and MCO cannot agree to the response to the PRR, LDH will provide MCO with written notice that LDH will respond to the PRR over MCO's objections, specifying the date on which LDH will respond, which shall not be less than seven business days from the written notice. MCO has the right to seek injunctive or other judicial or administrative relief to prohibit LDH's response. If MCO elects to file a Petition for Injunctive Relief, Declaratory Judgment, or other process for judicial or administrative relief, MCO will promptly deliver a copy of the petition or other pleading to LDH, and thereafter shall keep LDH notified of any significant developments that would impact LDH's obligations under Public Records laws. LDH and MCO shall cooperate as necessary any such judicial or administrative proceeding and shall comply with the final judgment or other ruling or determination regarding PRR. If MCO does not file a Petition for Injunctive Relief or seek such judicial or administrative relief as specified above, LDH may respond to the PRR in the manner LDH determines appropriate.

AJ v LDH (3:19-CV-00324)

MCOs, including ABHLA, are required to comply with all court-ordered requirements.

This section explains the class-action lawsuit AJ v. LDH (3:19-CV-00324) and the implementation and operation of key provisions of the settlement agreement in that litigation.

Class Members

All current and future Medicaid beneficiaries under the age of 21 in Louisiana who are certified in the Children's Choice Waiver, the New Opportunities Waiver, the Supports Waiver, or the Residential Options Waiver who are also prior authorized to receive extended home health (EHH) services or intermittent nursing (IN) services which do not require prior authorization but are not receiving some or all of the hours of extended home health services or intermittent nursing services as authorized by Louisiana Medicaid.

Litigation Summary

AJ v. LDH, filed on May 22, 2019, seeks to enforce rights under the EPSDT and reasonable promptness mandates of Title XIX of the Social Security Act, the Americans with Disabilities Act [42 U.S.C. §12131, et seq.], and Section 504 of the Rehabilitation Act [29 U.S.C. §794] by compelling the Department to arrange for the in-home skilled nursing care prior authorized for Medicaid-enrolled, medically fragile children. Because of their medical needs, class members have been prior authorized to receive EHH services to be able to live in the community. Data reflect gaps between the EHH service amounts prior authorized and the EHH service amounts actually delivered to class members. Potential service gaps in medically necessary IN services to class members also fall under the scope of the litigation. The suit has been settled, and the corresponding settlement agreement was approved by the court on March 31, 2020.

Prohibited Acts

ABHLA is prohibited from reducing prior approved EHH service amounts for *class members* to increase the percentage of prior approved EHH services actually delivered. Such reduction in the amount of services that have been prior approved is contrary to federal Medicaid law and would constitute a due process violation under the United States Constitution.

Settlement Implementation

ABHLA must adhere to the settlement agreement and implement it per the following:

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. ABHLA is responsible for accepting referrals from the CRT and arranging service fulfillment.

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 a need for IN has been identified and a class member 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. In such 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.

ABHLA must submit a weekly report to LDH documenting the actions taken to ensure service provision and fulfillment for CRT referral members. ABHLA must submit a monthly report detailing the hours and service provision for class members.

Class Member Denial Notices

Notices to class members denying EHH services must contain contact information for the CRT when there is an identified need for IN services, i.e., for in-home skilled nursing services of visits with a duration shorter than three contiguous hours per day.

Contact information for the CRT is as follows:

- E-mail: **crisisresponseteam@la.gov**
- Telephone: **1-866-729-0017**

Additionally, in situations when a class member is being referred to the CRT due to the unavailability of a provider for IN services concurrent with a termination from existing EHH services, the notice of denial to the class member of the EHH services termination must also notify the class member of the referral to the CRT.

Case Management

Support coordinators or case managers must document in the progress notes for each class member all prior approved EHH or medically necessary IN services and whether those EHH or IN services are provided, as reported by the family, including whether the family has refused the offered services and, if so, the basis for the refusal.

Additional Rate Modifiers

Louisiana Medicaid has published a Home Health Services Fee Schedule that includes modifiers with enhanced rates for EHH. Refer to **Rate Modifiers for Extended Home Health** for further information on how to apply these rate modifiers.

Termination

The settlement period for AJ v. LDH is scheduled to terminate on March 31, 2025, unless otherwise ordered by the court.

Chisholm v. LDH

Class members in Chisholm v. LDH (Case 2:97-cv-03274) are defined as follows: All current and future beneficiaries of Medicaid in the state of Louisiana under age twenty-one who are now on or will in the future be placed on the Developmental Disabilities Request for Services Registry.

ABHLA must comply with all court-ordered requirements as directed by LDH, including, but not limited to, guidance provided in the **Chisholm Compliance Guide** and accompanying MCO User Manual.

DOJ Agreement

The target population of the Department of Justice (DOJ) Agreement (Case 3:18-cv-00608, Middle District of Louisiana) are defined as follows: (a) Medicaid-eligible individuals over age 18 with serious mental illness (SMI) currently residing in nursing facilities; (b) individuals over age 18 with SMI who are referred for a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation of nursing facility placement during the course of this Agreement, or have been referred within two years prior to the effective date of this Agreement; and (c) excludes those individuals with co-occurring SMI and dementia, where dementia is the primary diagnosis.

ABHLA must comply with all court-ordered requirements as directed by LDH, including, but not limited to, guidance provided in the **DOJ Agreement Compliance Guide.**

Monitoring of Denial Notices

LDH monitors denial and partial denial notices to ensure compliance with federal requirements regarding timely and adequate notices of benefit determinations for prior authorized services. An auditing and monitoring process was established following the Wells v. Gee litigation (Case 3:14-CV-00155). As a result of the joint stipulation from the Wells v. Gee settlement, LDH developed multiple templates to help the MCOs maintain compliance with federal requirements as it pertains to the development of denial and partial denial notices of prior authorized services.

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This appendix provides a reference for all Louisiana Medicaid program updates.

Informational Bulletins

The following table provides a list of links to the Informational Bulletins issued by the Louisiana Department of Health since March 1, 2021. Click the IB Number to follow the link to the corresponding bulletin. For additional information, see the Louisiana Department of Health's Medicaid **Informational Bulletins Page**.

IB Number	Date Issued or Revised	Summary
25-17	06/09/2025	Announces update of FFS files with 2025 HCPCS changes and sets timeline for recycling of claims
25-16	05/09/2025	Announces additional third party liability carrier code changes
25-15	05/02/2025	Announces fee schedule enhancements to comply with CMS transparency requirements
25-14	04/23/2025	Clarifies provider enrollment requirements regarding periodic revalidation
25-13	04/23/2025	Clarifies dental HCPCS code G0330 and CPT code 41899 appropriate usage and meaning
25-12	04/09/2025 04/10/2025 (UPDATED)	Introduces pro service fee schedule update for specific LSU payment groups
25-11	04/02/2025	Reports incorrect denial resulting from to carrier code consolidation ensuring correction
25-10	03/28/2025	Moves St Tammany parish to MSA code 43640 effective 10/01/24
25-9	03/18/2025	Expands the definition of QHCP to allow pediatricians screening with the MCHAT-R/F, and clinical judgment, to make an autism diagnosis and complete a comprehensive diagnostic evaluation
25-6	02/28/2025	Outlines mandatory dental coverage for EPSDT eligible beneficiaries
25-5	02/21/2025	Exempts Donor Human Milk Banks from enrollment in the Medicaid provider registration program and certain DME accreditation requirements.
25-4	01/31/2025	Issues guidelines for CPT 90611 JYNNEOS Vaccine.
25-3	01/31/2025	Authorizes POS code 27 for services provided in a non-permanent location not already described by another POS.
25-2	01/31/2025	Introduction of Acadian ED Reduction Pilot Program
25-1	01/09/2025	Announces Third Party Referral Module for TPL Portal.
24-49	12/13/2024 05/13/2025 (UPDATED)	Requires DME ordering and referring providers are individuals and are listed on claim forms. Providers must be enrolled with the state. (UPDATED) removes referring provider requirements. Changes implementation timeline to 60 days
24-48	12/13/2024	Announces 2025 system/fee schedule update to be completed by end of January 2025
24-47	12/13/2024	Adds exclusions to the requirement that states screen and enroll all Medicaid providers that order, prescribe, or refer items or services to Medicaid beneficiaries

24-46	12/02/2024	Announces BTPL search function for LDH GWT-HMS TPL Portal
24-45	11/19/2024	Update to fee schedule for children/adolescents to include coverage of the influenza trivalent (IIV3) vaccine through Vaccines for Children Program
24-44	11/19/2024	CMS approval of and guidance on the use of POS 27 for LA Medicaid providers
24-43	11/18/2024	Address provider inquiries related to and provides guidance on procedure code modifiers.
24-42	10/31/2024 11/19/2024 (UPDATED)	Outlines rate changes to the immunization fee schedule for influenza vaccines and VCF (UPDATED) Links to IB 24-45 for updates related to IIV3 vaccine for children
24-41	10/29/2024	Outlines changes to DME provider manual regarding oxygen equipment and supplies during an official state and/or federally declared emergency
24-40	10/29/2024	Opens LDH/Gainwell Technologies Health Management Systems Third Party Liability Portal to providers and state partners for carrier code management
24-39	10/23/2024	Requests providers hold claims with new TPL during Gainwell data migration 11/4/24-11/19/24
24-38	10/18/2024	Update of CAT form for use with both Medicare and Medicaid
24-37	10/15/2024	Updates fee schedule for 2024/2025 influenza vaccine coverage
24-36	10/14/2024	Updates carrier code for certain Medicare Advantage plans
24-35	10/10/2024	Outlines changes to the State Plan Amendment to align with the passage of HB655/Act 486 regarding third party liability
24-34	09/30/2024	Adds coverage of disposable (elastomeric) infusion pumps
24-33	09/26/2024	Outlines 2025 Open Enrollment dates and limitations
24-32	09/20/2024 10/29/2024 (UPDATED)	Introduces temporary rate increases for SUD providers for DOS 10/1/24-06/30/25 (UPDATED) Increases rate by 50% for DOS 12/1/24-06/30/25
24-31	09/18/2024	Coverage of respiratory viral panels and medical necessity requirements
24-30	09/16/2024	Update to the vision benefit fee schedule and reimbursement rate increase. Also updates code S0580 to V2784
24-29	09/09/2024	Memorandum and Guidance regarding Act 246 and revision of Schedule IV controlled substances drug list
24-28	08/28/2024	Reminds MCOs of the importance of appropriate CARC/RARC codes

24-27	08/05/2024 08/23/2024 (UPDATED) 10/28/2024	Adds coverage of TMS for major depression and persistent depressive disorder Removes persistent depressive order as diagnosis for treatment Removes failure of EBT as a criteria, adds retreatment and contraindications criteria
24-26	07/31/2024	Adds Brief Emotional/Behavioral Assessment code 96127 as a covered service
24-25	07/31/2024	Expands mental health professional specialties eligible for reimbursement
24-24	07/18/2024	Adoption of AAN criteria for brain death determination as of 3/1/24
24-23	07/02/2024	Substitutes coverage of CPT 77387 with coverage of G6001 and G6002 for radiation therapy
24-22	06/27/2024 08/23/2024 (UPDATED) 10/28/2024	Process for newly contracted providers to enroll in mandatory Medicaid Provider Portal (UPDATED) Delays project with no expected start date (UPDATED) 10/25/2024 start date
24-21	06/13/2024	Update to Carrier Code Listing for TPL
24-20	06/13/2024	Outlines the utilization of X-modifiers in place of modifier 59
24-19	06/05/2024	Introduces new formal process for requesting policy change and new benefit coverage from LDH
24-18	06/05/2024 07/18/2024 (UPDATED) 08/23/2024 (UPDATED)	Extends coverage of screening mammography to women aged 30 and above. (UPDATED) Outlines documentation effect on processing (UPDATED) Removes documentation conditions
24-17	05/22/2024	Added coverage of Corneal Collagen Cross-Linking effective 5/1/24.
24-16	05/22/2024	Effective 5/1/24, proprietary laboratory analysis only covered in facility, observation and/or inpatient setting.
24-15	05/15/2024	Effective 7/1/24, PDL updated to include both brand and generic versions of drugs
24-14	05/14/2024	Effective 5/1/24, beneficiaries enrolled in EPSDT, Adult Waiver, and ICF dental programs are eligible for one preventative dental sealant application per tooth every 36 months
24-13	05/06/2024	Announces changes to ABA manual including provider requirements and coding guidance
24-12	05/01/2024	Introduces LDH's provider directory project for network adequacy

24-11	04/08/2024	Updates fee schedule in accordance with changes announced in IB 24-10
24-10	04/03/2024	Effective January 16, 2024, Louisiana Medicaid no longer applies the NCCI MUE to claims submitted by Provider Type 70 containing HCPCS codes representing services provided by non-practitioners
24-9	04/02/2024	Allows individual speech therapists, physical therapist, and occupational therapists to enroll as individual providers in Medicaid FFS plans and provides billing guidance
24-8	04/02/2024	Updated EMT fee schedule methodology and air ambulance reimbursement rates effective 7/1/23
24-7	03/27/2024 10/29/2024 (UPDATED)	Updated coverage for electronic breast pumps effective 03/01/24 (UPDATED) Added new form with mother's DOB
24-6	03/08/2024	Correction to and guidance on claims payments for newborns incorrectly enrolled and re-enrolled in an MCO
24-5	02/07/2024	Reminder about the Medicaid PDHC policy and restrictions
24-4	02/02/2024 (UPDATED) 04/02/2024, 11/13/2024, 02/25/2025	outlines the options available to ambulance providers for pursuing resolution of claims payment issues (UPDATED) Updated contact information
24-3	01/31/2024	Gives updates to the immunization fee schedule
24-2	01/31/2024 06/13/2024 (UPDATED) 06/26/2024 (UPDATED)	Informs of updates to the ASAM criteria for adult substance use services (UPDATED) Effective January 1, 2026 (UPDATED) Clarifies that adoption of ASAM Criteria 4th edition is not guaranteed
24-1	01/18/2024	Informs of the expected upload of the 2024 HCPCS to the fee schedule
21-2	REVISED: 05/21/2021, 03/07/2023, 06/15/2023, 11/13/2024, 02/03/2025, 02/25/2025	LDH issued guidelines and contact information for pursuing resolution of transportation claims payment issues. (REVISED 03.07.23, 06.15.23, 11.13.24) LDH updated contact information for pursuing resolution of transportation claims payment issues.
19-3	12/16/2021 (REVISED) REVISED: 02/10/2023, 04/10/2023, 04/13/2023, 06/15/2023, 07/31/2023, 11/28/2023, 12/18/2023, 03/04/2024, 04/02/2024, 08/23/2024, 02/03/2025, 02/25/2025	The Medicaid Managed Care Provider Issue Resolution bulletin was updated. (REVISED 02.10.23) Reduces the number of days allowed for MCOs to correct and readjudicate claims due to MCO error from 30 to 15 calendar days (REVISED) Updated contact information (REVISED) Added Pharmacy Helpdesk contact information

16-15	02/20/2025 (REVISED)	Updates TPL Medicare Advantage plan update requests protocol to include TPL portal and escalation methods.

APPENDIX B: ADDITIONAL RESOURCES

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This appendix provides additional resources for providers.

Louisiana Medicaid Provider Manuals

Providers must be aligned with all current Louisiana Medicaid Provider Manuals. For more information about Louisiana Department of Health's Medicaid guidelines, refer to links to each manual in the table below.

Louisiana Medicaid Provider Manuals	
Administrative Claiming	Home Health
Adult Day Health Care Waiver	Hospice
Ambulatory Surgical Centers	Hospital Services
American Indian 638 Clinics	Independent Laboratories
Applied Behavior Analysis	Intermediate Care Facilities For Individuals With Developmental Disabilities
Behavioral Health Services	LaHIPP Claims
Case Management Services	Medical Transportation
Children's Choice Waiver	New Opportunities Waiver
Community Choices Waiver	PACE
Dental	Pediatric Day Health Care
Durable Medical Equipment	Personal Care Services (LT-PCS and EPSDT-PCS)
End Stage Renal Disease	Pharmacy
Epsdt Health And Idea - Related Services	Portable X-Ray
Epsdt Health And Idea, Part C - Earlysteps	Professional Services
Family Planning - Take Charge Plus	Residential Options Waiver
Family Planning Clinics	Rural Health Clinics
Federally Qualified Health Centers	Supports Waiver
Free Standing Birthing Centers	Vision (Eye-Wear)
General Information And Administration	

Louisiana Medicaid Provider Manual Updates

This section captures updates from the Louisiana Medicaid Provider Manual not located elsewhere in the ABHLA Provider Manual.

Residential Options Waiver

Effective 4/20/2021, the Louisiana Department of Health (LDH) updated the Residential Options Waiver Provider Manual. Updates were made in Appendix E: Billing Codes. Aetna Better Health of Louisiana is configuring its systems to align with these updates.

Pharmacy

Effective 4/26/2021, the Louisiana Department of Health (LDH) updated the Pharmacy Benefit Management Services Manual. Updates were made in Section 37.1: Covered Services, clarifying and revising criteria for drugs with special payment criteria/limitations. Providers should familiarize themselves with these updates and with the Aetna Better Health of Louisiana Formulary/Single PDL at **https://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf**.