POLICY AND PROCEDURE

POLICY NAME: Covered Benefits and Services	**POLICY ID:** LA.UM.01.01
BUSINESS UNIT: LHCC	**FUNCTIONAL AREA:** PHCO
EFFECTIVE DATE: 09/01/2011	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 10/13, 1/14, 11/14, 4/15, 7/15, 9/15, 2/16, 5/16, 7/16, 4/17, 4/18, 4/19, 5/19, 2/20, 3/21, 6/22, 12/22; 02/23	
REGULATOR MOST RECENT APPROVAL DATE(S): n/a	

POLICY STATEMENT:
This policy outlines covered benefits and services.

PURPOSE:
The purpose of this policy and procedure is to outline the list of covered benefits and services offered to Plan enrollees ensuring enrollees have available, at a minimum, those core benefits and services, and any other services as provided through the 1915(i) SPA, 1915(c), and 1915(b) waivers specified in the Louisiana Department of Health Model Contract, MCO Manual and MCO Covered Services attachment B and as defined by the Louisiana, administrative rules and Department policies and procedure manuals. (Model Contract 2.4.1.1)

The Plan shall provide MCO Covered Services in accordance with LDH's definition of medically necessary services (see Glossary), including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and the MCO Manual. [42 C.F.R. §438.210(a)(5)(i)] (Model Contract 2.4.1.5)

SCOPE:
Louisiana Healthcare Connections (Plan) Population Health and Clinical Operations and Enrollee Service departments

DEFINITIONS:
Covered Services: Those health care services/benefits to which an individual eligible for Medicaid/CHIP is entitled under the Louisiana Medicaid State Plan.

Inpatient Hospital Care: Inpatient hospital care is defined as care needed for the treatment of an illness or injury which can only be provided safely and adequately in a hospital setting and includes those basic services that a hospital is expected to provide. The MCO shall not reimburse for care that can be provided in the home or for which the primary purpose is of a custodial or cosmetic nature.
Experimental Services: A procedure or service that requires additional research to determine safety, effectiveness, and benefit compared to standard practices and characteristics of patients most likely to benefit. The available clinical scientific data may be relatively weak or inconclusive. The term applies only to the determination of eligibility for coverage or payment.

Medically Necessary Services: Those health care services that are in accordance with generally accepted evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care (LA Administrative Code). In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the Beneficiary. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the Beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Louisiana Medicaid Program. Services that are experimental, non-Food and Drug Administration (FDA) approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

~~Services, supplies, or equipment provided by a licensed health care professional that: a. are appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury; b. are in accordance with the standards of good medical practice consistent with the individual patient's condition(s); c. are not primarily for the personal comfort or convenience of the Enrollee, family, or Provider; d. are the most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Enrollee; e. are furnished in a setting appropriate to the patient's medical need and condition and, when applied to the care of an inpatient, further mean that the Enrollee's medical symptoms or conditions require that the services cannot be safely provided to the Enrollee as an outpatient; f. are not~~

~~experimental or investigational or for research or education; g. are provided by an appropriately licensed practitioner; and h. are documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service. The only limitation on services for children is that they are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an EPSDT screen, periodic or inter-periodic, whether or not such services are covered or exceed the benefit limits in the Medicaid State Plan. All services determined to be medically necessary must be covered. A public health quarantine or isolation order or recommendation also establishes the medical necessity of healthcare services. (Model Contract 2.4.1.5.1)~~

Second Opinion: Subsequent to an initial medical opinion, an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service.

POLICY:

The Plan, at a minimum, provides benefits and services that are reasonable and medically necessary for the diagnosis or treatment of a~~n~~ disease, condition, and/or disorder that results in health impairments and/or disability~~illness or injury or are preventive in nature~~, ensure the ability to achieve age-appropriate growth and development, or the ability to attain, maintain, or regain functional capacity. (Model Contract 2.4.1.6.2-3) Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished to Beneficiaries under FFS, as set forth in 42 CFR §440.230, and for enrollees under the age of twenty-one (21), as set forth in 42 CFR Part 441, Subpart B. [42 CFR §438.210(a)(2)] (Model Contract 2.4.1.3 and 2.12.3.3) ~~and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan as specified in 42 CFR §438.210(a).~~

The Plan will educate and monitor providers to ensure that the enrollee is held harmless by the provider for the costs of medically necessary core benefits and services (Model Contract 2.12.7.2.4). Except for cost sharing that does not exceed the cost sharing amounts in the State Plan, the Contractor shall ensure that Enrollees are held harmless for the cost of MCO Covered Services provided as of the effective date of Enrollment with the Contractor (2.3.12.2.5).

The Plan shall not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources. (Model Contract 2.4.1.8)

The Utilization Management (UM) Program aims to reduce inappropriate and duplicative use of health care services and provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care, including but not limited to non-emergent use of hospital Emergency Departments. (Model Contract 2.4.1.9) Services shall be managed to promote utilization of best, evidenced-based, and informed practices and to improve access and deliver efficient, high-quality services. The Plan will not arbitrarily deny or reduce the amount, duration, or scope of required services solely because of diagnosis, type of illness or condition of the enrollee. (Model Contract 2.12.3.2) The Plan shall screen enrollees to determine level of need for the purpose of service authorization based on medical necessity. Based on this medical necessity determination, the Plan shall authorize Medicaid State Plan services as appropriate.

The Plan is responsible for all core benefits and services as long as an enrollee is enrolled in the plan, including periods in which the enrollee is admitted to a long-term care facility/nursing home for rehabilitative purposes and prior to the time the enrollee is disenrolled from the plan.

The Plan shall provide coverage of and be financially responsible for medically necessary durable medical equipment, prosthetics, orthotics, certain supplies, appliances, and assistive devices including, but not limited to, hearing aids for enrollees under the age of 21. DME for those under 21 includes disposable incontinence supplies and enteral formulas.

The Plan shall not portray core benefits or services as a value-added benefit or service.

The Plan may request to be notified by the provider, but shall not deny claims payment based solely on lack of notification, for the following:

- Obstetrical care (at first visit); and
- Obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery and ninety-six (96) hours after Caesarean section

PROCEDURE:

1. The Plan may place appropriate limits on a service (a) on the basis of certain criteria, such as medical necessity; or (b) for the purpose of utilization control (with the exception of EPSDT services) (Model Contract 2.12.8.7), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210 (Model Contract 2.4.1.4). The services support enrollees with ongoing or chronic conditions and are authorized in a manner that reflects the Enrollee's ongoing need for such services and supports. (Model Contract 2.4.1.4.2.2) The Plan shall provide the PASRR Level II authority (Office of Behavioral Health) with documentation supporting appropriate limits on a service on the basis of medical necessity for individuals determined by the PASRR Level II authority to need specialized behavioral health services.). No medical service limitation can be more restrictive than those that currently exist under the Title XIX Louisiana State Medicaid Plan – upward variances of amount duration and scope of these services are allowed.
2. The Plan requires prior authorization for only those procedures and services for which the quality of care or financial impact can be favorably influenced by medical necessity or appropriateness of care review, such as non-emergent inpatient admissions (other than normal newborn deliveries) (Model Contract 2.12.8.7), all out-of-network services and certain outpatient services and ancillary services as described on the Prior Authorization List.
3. Core Covered Benefits and services are outlined in the table below.

Covered Services:	**Comments:**
Abortion (Elective)	Covered only when medically necessary to save the life of the mother or if pregnancy is the result of rape or incest. (42 CFR 441.200 et seq support E) Must submit correctly completed Louisiana "Certification for Informed Consent-Abortion" with claim.
Acute Medical Detoxification	Urgent/Emergent admissions require notification within one (1) business day.
Ambulance – Airplane	Prior Authorization required for all non-emergent fixed wing (airplane) Ambulance Services.
Ambulance – Emergent	Includes emergency ground and emergency helicopter ambulance. Prior authorization required when transporting to out-of-state location.
Ambulance -- Non-Emergency	Prior Authorization required only when transporting to out-of-state location.
Ambulatory Surgery Center Services	Prior Authorization required for elective/scheduled inpatient admissions. For Outpatient scheduled procedures, also refer to the Prior Authorization List/ARQ for specific codes as well as review Participating versus Non-Participating status to determine if authorization is required.
Antepartum Care	Must be billed as individual visit services are rendered, not global antepartum or global delivery codes.
Applied Behavioral Analysis Therapy (age 0-20)	Authorization required
Audiology Services	Refer to Prior Authorization List/ARQ for specific codes.
Basic Behavioral Health Services	
Biopharmaceutical Drugs	Prior Authorization is required for selected J-Codes when administered/dispensed in a provider's office, outpatient facility, or in the home. Refer to Prior Authorization List/ARQ.
Breast Pump	Covered without need for prior authorization for nursing mothers. Eligible for one double-electric breast pump per delivery. Breast pump supplies will be covered once every 180 days with prescription. Replacement pumps will be covered within three years of date of request and following expiration of the manufacturer's warranty.
Chiropractic Services	Prior Authorization required. Covered under age 21 years. Refer to Prior Authorization List/ARQ for specific codes.
C-Section	A length of stay beyond 4 days requires inpatient notification.
Clinic Services	Including Non-IEP Medicaid covered services provided in schools and when such services are not funded through certified public expenditures.

Covered Services:	Comments:
Cochlear Implants	Prior Authorization required for cochlear implants. Refer to Prior Authorization List/ARQ for specific codes. Ear molds and batteries do not require authorization.
Communicable Disease Services	Includes testing and treatment.
Dental - General Anesthesia	No authorization required.
Dental- Emergency, Medical, & Surgical	Prior Authorization is required for services performed by an oral surgeon in the office. Routine/preventive dental is covered by Louisiana Medicaid. As a value-added benefit, dental services are covered for enrollees over 21 years of age. Refer to Value Added Benefits for full notation of coverage.
Dental- Non-Emergency, Medical, & Surgical	Coverage for all ages per LHCC Value Added Benefits (refer to Value Added Benefits info for full notation of coverage).
Dialysis	Includes free standing and outpatient hospital setting. Prior Authorization is required for any biopharmacy and Non-Par provider.
Durable Medical Equipment – Appliances and Supplies	Prior Authorization required. See Authorization List Below (examples, not all inclusive): • Apnea Monitor • BiPAP • Bone Growth Stimulator • CPAP • Custom Compression Burn Garments • Gait Trainers • Hospital beds • Infusion Pumps • Power and standard wheelchairs • Traction equipment • Wheelchairs • Wound Vacuum • Miscellaneous DME over $2000
Early Periodic Screening Diagnosis and Treatment (EPSDT)	For enrollees under 21 years of age. EPSDT/ Well Child Services (Previously KidMed).
Emergency Room Services	Services rendered in an ER place of service by non-participating providers will be reimbursed at 100 percent of the Medicaid rate for emergency services.
End Stage Renal Disease Services	
Enteral/Parenteral Nutrition for Home Use	Prior Authorization is required.
Family Planning Services	Includes “Well Woman” exams, screenings, pregnancy testing, prescription birth control pills, Mirena, and other Intra-Uterine Devices.
Federally Qualified Health Centers (FQHC) & Rural Health Clinic (RHC)	No Authorization required.
Fluoride Varnish	Covered by PCP. No Prior Authorization required; however, only certain PCP’s are certified to provide these services. Please contact Provider Services for a listing of eligible providers prior to obtaining services.
Genetic Testing	Prior Authorization required for select codes. Refer to Prior Authorization List/ARQ.
Hearing Aids and Batteries	For enrollees under 21 years of age: Molds V5264 and batteries do not require authorization. As a value-added benefit: For enrollees under 21 years of age, one annual hearing exam and one (1) set of hearing aids, every two (2) years.

Covered Services:	Comments:
High Tech Imaging	Prior Authorization required for CTA, MRA, MRI, PET Scans. Service managed by Magellan Healthcare (NIA). Cardio Nuclear imaging requires Prior Authorization and is code specific as to whether or not this is authorized through Magellan Healthcare (NIA) or by the Plan. Refer to Prior Authorization List/ARQ.
Home Health Care Services	Prior Authorization required and visits are unlimited for any age. Services include but are not limited to: Skilled Nursing Services, Home Health Aide, Home Infusion and Wound Therapy. Home Therapy (Physical, Occupational, and/or Speech) is managed by Magellan Healthcare (NIA). Home Health Extended Care is available for enrollees under 21 years of age only.
Home Health Care Services -- OB	Prior Authorization is required. 17P/Makena Administration, Hypertension, Preeclampsia, N&V (Zofran/Reglan pumps), DM, NST, Preterm Labor Management.
Hospice Care	Prior Authorization is required.
Hyperbaric Oxygen Therapy	Prior Authorization is required.
Hysterectomy	Prior Authorization is required. Must submit copy of Louisiana “Acknowledgment of Receipt of Hysterectomy Information Form” with claim.
Immunizations	Includes children and adults. Providers must participate in Vaccines for Children (VFC) for child immunizations.
Inpatient Hospital Services	Prior Authorization required for those services and procedures noted elsewhere on this list (hysterectomy, potentially cosmetic etc.). The MCO shall require prior authorization for out-of-state non-emergency hospitalization, unless the request for hospitalization is for a dual Medicare/Medicaid eligible enrollee. Additional service authorization requirements and exclusions are defined in the Contract (MCO Manual)
Laboratory Services	Must use Network Provider. Refer to Prior Authorization List/ARQ for specific codes.
Locum Tenen	Prior Authorization must be obtained for Locum Tenen Services if practitioner is not credentialed with the facility through the Plan.
Maternity Care Services	Prenatal through Postpartum. Submit Notice of Pregnancy (NOP) form at first visit.
Neuro-Psychological Services	Prior Authorization required. Based on diagnosis, may be authorized by Plan. Refer to Prior Authorization List/ARQ.
Nurse Midwife and Nurse Practitioner Services	No authorization required.
Observation	Prior Authorization is required for Observation stays which exceed 48 hours
OB Ultrasound	76811 and 76812 may be billed by Perinatologist and Maternal Fetal Specialist only. No Authorization is required.
Oral Surgeon Services	Prior Authorization required for procedures conducted by an oral surgeon.
Orthotics	Certain codes are age specific. Refer to Prior Authorization List/ARQ.
Out-of-Network Physician & Facility	Prior Authorization is required for all Out-of-Network provider/facility requests, excluding emergency department (ED) services, family planning services, and table top x-rays.
Outpatient Hospital Services	

Covered Services:	Comments:
Pain Management Services	Prior Authorization is required for services, including pain/nerve blocks, epidural injections, neuro-stimulators (both in office and outpatient), except for acute post-operative pain.
Pediatric Day Healthcare Services (age 0-20)	Authorization required
Personal Care Services	Prior Authorization is required. Limited to 0-20 years of age. (Model Contract 2.4.2.1.3).
Physician/Professional Services	
Primary Care Physician (PCP), Physician Assistant, Nurse Practitioner and Specialist Office Visits	Prior Authorization is required for all Out-of-Network services, excluding emergency room (ER) services, family planning services, and table top x-rays.
Plastic Surgery	Prior Authorization is required for all treatments & procedures in office or outpatient setting. Not a covered benefit for cosmetic purposes.
Podiatrist Services	No Authorization required excluding services performed by an Out-of-Network provider. Refer to Prior Authorization List/ARQ for specific codes.
Prescription Drugs	Managed by Envolve Pharmacy Solutions. Envolve Pharmacy Solutions, the Plan's pharmacy benefit manager, processes pharmacy claims and administers the Medication Prior Authorization process. The Medication Prior Authorization form should be used when submitting prior authorizations or medical necessity requests. Refer to Preferred Drug List and Prior Authorization List/ARQ.
Pregnancy-Related Services	
Procedures/Surgery	Prior Authorization is required for all participating provider status in any setting for the following: • Bariatric Surgery • Blepharoplasty • Breast Reconstruction /Reduction • Laminotomy • Tonsillectomy & Adenoidectomy • Otoplasty • Rhinoplasty • Varicose Vein Treatments • Hernia Repair For Outpatient scheduled procedures, also refer to the Prior Authorization List/ARQ for specific codes as well as review Participating versus Non-Participating status to determine if authorization is required.
Prosthetics	Prior Authorization may be required for selected codes. Refer to Prior Authorization List/ARQ.
Radiation Therapy	Prior Authorization is required.
Radiology and X-Rays	Routine X-Rays – No authorization is required. Prior Authorization is required for high-tech radiology including CT, MRI, MRA, PET Scan. Services requested for high-tech radiology are managed by Magellan Healthcare (NIA). See OB Ultrasound.
School-Based Health Clinic Services	No authorization required, except as otherwise noted on the list.
Sleep Study	Prior Authorization is required for Sleep Studies performed in home or outpatient settings.
Specialized Behavioral Health Services	Psychiatry (all Ages) LMHP Licensed Practitioner Outpatient Therapy Community Psychiatric Support and Treatment (CPST) Multi-Systemic Therapy

Covered Services:	Comments:
	Functional Family Therapy (FFT – under age 21) Homebuilders (under age 21) Assertive Community Treatment (ACT – limited to 18 years and older) Psychosocial Therapy (PSR) Crisis Intervention Crisis Stabilization (age 0-20) Therapeutic Group Homes (TGH) (age 0-20) Peer Support Services (age 21 and older) Psychiatric Residential Treatment Facilities (PRTF – under age 21) Inpatient hospitalization (age 21 and under; 65 and older) Outpatient, Residential and Inpatient Substance Use Disorder in accordance with American Society of Addition Medicine (ASAM) Screening for services (including Coordinated Systems of Care – CsoC) Permanent Supportive Housing Medication Assisted Treatment Agreement Target Population Crisis services (MCR, CBCS, BHCC) -21 and up Individual Placement Support IPS PCS for DOJ
Specialty Injection and/or Infusion Services	Prior Authorization is required for selected codes. Refer to Prior Authorization List/ARQ.
Sterilization Services	No authorization required. Must submit “Consent for Sterilization Form” with claim.
Telemedicine	
Therapy (PT,OT,ST) Services (Outpatient)	Initial Evaluation visit does not require authorization. Prior Authorization required for all subsequent visits/treatment and review performed by Magellan Healthcare (NIA). Providers must submit treatment plan & goals for continued services. Must bill with the appropriate G-Modifiers. Services are managed Excludes specified Early Steps Services.
Tobacco Cessation Services	
Transplant Services	Prior Authorization is required for all transplant services including transplant evaluation, pre- and post-services. Processed through Central Transplant Unit.
Transportation Non-Emergency	For enrollees who lack transportation to/from Medicaid covered services.
Urgent Care Center	No authorization required if place of Service/Location = 20.
Vision Services and Eyewear	Routine screening, corrective and medical services covered for enrollees under 21 years of age. Maximum of three (3) pairs of glasses per calendar year or contacts, with Prior Authorization, covered for enrollees under 21 years of age. As a value-added benefit: Annual routine exam and refraction covered for enrollees 21 years of age and older. One (1) pair of frames and lenses per calendar year covered for enrollees 21 years of age and older. Services managed by Envolve Vision.

4. The Plan may choose to offer additional benefits that are outside the scope of core benefits and services to individual enrollees on a case-by-case basis, based on medical necessity, cost-effectiveness, the wishes of the enrollee and/or

enrollee's family, the potential for improved health status of the enrollee, and functional necessity that are met as required in 42 C.F.R.§438.3(e)(2)(i)-(iii). (Model Contract 2.4.4.1-2.4.4.2 & 2.4.4.3)

- The enrollee is not required by the plan to use the alternative services or setting
- The Plan may submit additional in lieu of services to LDH for prior approval and include a plan for identifying and reporting the utilization of in lieu of services

Value–added benefits and services are those optional benefits and services offered by the Plan, including those that are:

- Core benefits and services
- Cost-effective alternatives (Model Contract 2.4.5)

5. Behavioral Health Services Plan will cover basic behavioral health services which include, but are not limited to, screening, prevention, early intervention, medication management, and referral services as defined in the Medicaid State Plan. Basic behavioral health services may further be defined as those provided in PCP or medical provider office by the enrollee's physician as part of routine physician evaluation and management activities Specialized behavioral health services shall include, but are not limited to services specifically defined in the Medicaid State Plan or any other services as provided through the 1915(i) SPA, and 1915(c), and 1915(b) waivers and are provided by psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, mental health clinics, mental health rehabilitation service providers (public or private). Specialized behavioral health services shall also include any other behavioral health service subsequently amended into the Medicaid state plan or waivers.)

6. Lab and Radiological Services The Plan shall provide inpatient and outpatient diagnostic laboratory testing, therapeutic radiology, and radiological services ordered and/or performed by all network providers. For excluded services such as dental, the Plan is responsible for laboratory or radiological services that may be required to treat an emergency or provide surgical services. The Plan shall provide for clinical lab services and portable x-rays for enrollees who are unable to leave their place of residence without special transportation or assistance to obtain PCP ordered laboratory services and x-rays.

7. Federally Qualified Health Centers (FQHCs) The Plan will provide enrollees with access to services provided through a FQHC whether or not the FQHC has a contract with the Plan, if:
    - the enrollee resides in the service area in which the FQHC is located, and
    - the enrollee requests such services.

    a) If the Plan has at least one FQHC in its provider network in the service area and allows enrollees to receive medically necessary services from the FQHC, the Plan does not need to allow enrollees to access FQHC services out-of-network.
    b) The Plan will allow enrollees to receive medically necessary services to treat an emergency medical condition from the out-of-network FQHCs (See §4.21 of the Provider Agreement) if the Plan does not include a FQHC in their provider network and a FQHC exists in their designated service area.
    c) The Plan will reimburse FQHCs based upon rates no less than the Medicaid Prospective Payment Rates established by LDH and in accordance with *§ 2.2 Payment to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHC)* of the Provider Agreement.
    d) The Plan may stipulate that reimbursement will be contingent upon receiving a clean claim and all the medical records information required to update the enrollee's medical records.

8. Responsibilities with respect to Chisholm vs. Gee Class
    a) The Plan must maintain an outreach and referral system to direct class enrollees with an Autism Spectrum Disorder diagnosis to qualified healthcare professionals, who can provide Comprehensive Diagnostic Evaluations required to establish medical necessity for Applied Behavior Analysis services.
    b) In addition, the court settlement applies to and ensures necessary psychological and behavioral services described in 42 U.S.C. § 1396d(a), including diagnostic services and treatment, to correct or ameliorate defects and physical and mental illnesses and conditions must be provided by the state to those enrollees of the Chisholm class, who meet the criteria listed in the stipulation.

9. Second Opinions Authorization for a second opinion will be granted to a network provider, or an out-of-network provider if there is no in-network provider available, when there is a question concerning diagnosis or options for surgery or other treatment of a health condition or when requested by any enrollee of the enrollee's health care team, the enrollee, parent and/or guardian(s), or a social worker exercising a custodial responsibility. Second opinions**,** whether from an in-network or an out-of-network provider, will be granted at no cost to the enrollee.

10. Out-of-Network Services In some cases it may be necessary for services to be provided by an out-of-network provider. The Plan will reimburse non-network providers for core benefits and services if the service was medically necessary, authorized by the Plan, and could not reasonably be obtained by a network provider, inside or outside the state of Louisiana on a timely basis. Core benefits and services are considered authorized if the Plan does not respond to a request for authorization within the time frame specified in the associated Timeliness of UM Decision policy LA.UM.05.
    a) The decision to authorize use of an out-of-network provider will be based on continuity of care, availability and location of an in-network provider of the same specialty and expertise, and complexity of the case.
    b) Services will be authorized as long as the service is needed or until the service can be provided by an in-network provider, whichever comes first.
    c) The Plan will coordinate payment with the out-of-network provider and ensure the cost to the provider is not greater than it would be if the services were furnished by an in-network provider.
    d) The Plan will coordinate with the out-of-network provider with regard to payment and communicating with the enrollee's other treating physicians/PCP.

11. Moral or Religious Objections: The Plan is required to provide and reimburse for all Covered Services. If, during the course of the contract period, in accordance with 42 U.S.C. §1396u-2(b)(3)(B) and 42 C.F.R. §438.102(b)(1), the Plan elects not to provide, reimburse for or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, the Plan will furnish information about the service it does not cover as follows:
    a) With its letter of request to LDH to enroll as a MCO or immediately upon adoption if during the term of the MCO Provider Agreement;
    b) To potential enrollees before and during enrollment, via the Enrollment broker;
    c) To enrollees within 90 calendar days after adopting the policy, with respect to any particular service, but no more than 30 calendar days before the effective date of the policy.
    d) To enrollees through the inclusion of the information in the Member Handbook

    For counseling or referral services that the Plan does not cover because of moral or religious objections, the Plan should direct the enrollee to contact the Enrollment Broker for information on how or where to obtain the service. (Model Contract 2.4.6)

    Note: Louisiana Healthcare Connections is not limiting coverage of counseling or referral services because of, but not limited to, objection on moral or religious grounds.

12. Excluded Services: Services defined as those services that enrollees may obtain under the Louisiana State Plan or applicable Waivers, and for which the Plan is not financially responsible. However, the Plan is responsible for informing enrollees on how to access excluded services, providing all required referrals, and assisting in the coordination of scheduling such services. These services shall be paid for by LDH on a fee-for-service basis or other basis. (Model Contract 2.4.2.1)
    a) The following services are paid by LDH on a fee-for-service basis:
        - Services provided through LDH's Early Steps Program (Individuals with Disabilities Education Act (IDEA) Part C Program Services)
        - Dental, with the exception of the ESPDT varnishes provided in a primary care setting surgical dental services and emergency dental services (Model Contract 2.4.2.1.1)
        - Intermediate Care Facility (ICF)/Developmental Disabilities (DD) Services (Model Contract 2.4.2.1.2)
        - Personal Care Services for those ages 21 and older with the exception of PCH for DOJ members (S5125) (Model Contract 2.4.2.1.3)
        - Nursing Facility Services with the exception of post-acute rehabilitative care provided at the discretion of the plan as a cost-effective alternative service to continued inpatient care (Model Contract 2.4.2.1.4)
        - School-based IEP services provided through the school district and billed through the intermediate school district, or school-based services funded with certified public expenditures (these services are not provided by OPH certified school-based health clinics) (Model Contract 2.4.2.1.5)
        - All Home and Community-Based Waiver Services with the exception of 1915(b) mandatory enrollment waiver, 1915(c) SED waiver, and 1915(i) SPA services (Model Contract 2.4.2.1.6);
        - Targeted Case Management Services including Nurse Family Partnership
    b) The following services are Prohibited Services under the Plan and the Louisiana Medicaid Program: (Model Contract 2.4.3.1-4)
        - Elective abortions and related services
        - Experimental/investigational drugs, procedures, or equipment (Phase I and Phase II treatments are considered experimental)

- Elective Cosmetic Surgery
- Services for treatment of infertility

13. The Medicaid Director in consultation with the Medicaid Medical Director and Medicaid Behavioral Health Medical Director will make the final interpretation of any disputes about the medial necessity and continuation of core benefits and services under the Emergency Contract based on whether or not the Medicaid fee-for-service program would have provided the service. (Model Contract 2.12.8.1)

REFERENCES:
LA MCO Model Contract
MCO Manual
MCO Covered Services
LA.UM.05 Timeliness, UM Decision and Notification
Code of Federal Regulations 42 CFR 422, 438, 441
Current NCQA Health Plan Standards and Guidelines
CMS finalized MEGA Rule May 2016

ATTACHMENTS:

ROLES & RESPONSIBILITIES:

REGULATORY REPORTING REQUIREMENTS:
Which regulator(s) require reporting, what should be reported, when to report, and how to report/who to contact.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	POLICY: changed the first bullet from: Inpatient emergency admissions within forty-eight (48) hours of admission to: Inpatient emergency admissions and post stabilization within two (2) business days of admission;	10/12
Ad Hoc Review	PROCEDURE**:** Updated the Core Covered Benefits and Services table to reflect current covered services.	10/13
Ad Hoc Review	Corrected typos	01/14
Ad Hoc Review	LA Procurement 2015 Policy Update	11/14
Ad Hoc Review	Change to current NCQA instead of date	04/24/15
Ad Hoc Review	Updates from BH amendments to RFP	09/29/15
Ad Hoc Review	Corrected reference to LA.UM.05. The number was missing	02/24/16
Ad Hoc Review	Removal of failure to notify within 1 business day as an exception to deny payment. Change CCN to MCO Renamed Radiation Therapy in benefits grid	05/24/16
Ad Hoc Review	Changed DHH to LDH Added Mega Rule verbiage to 11 d	07/25/16
Ad Hoc Review	Changed Cenpatico to Envolve Changed OptiCare to Envolve Changed US Script to Envolve Pharmacy Several sections added to list of Core Benefits and Services section to reflect current covered services	04/24/17
Ad Hoc Review	Changed Envolve to Envolve PeopleCare-Behavioral Health, Envolve Pharmacy Solutions, Envolve Vision specific to content Changed National Imaging Associates (NIA) to Magellan Healthcare (NIA) Deleted codes for specific services and added “Refer to Prior Authorization List/ARQ” Added RFP-Amendment 11 Citation & Reference Revisions	04/24/18

	Removed CCL-216 Policy from 9. Second Opinions and References	
Ad Hoc Review	Minor Grammatical Changes. Updated Core Covered Benefits & Services Table to reflect current coverage for Ambulance, Ambulatory Surgery Center Services, Breast Pump, C-Section, Dental Care, Durable Medical Equipment, Home Health Care, Inpatient Hospital Services, Observation, Podiatrist, Procedures/Surgery, Outpatient PT/OT/ST Therapy. Removed Envolve PeopleCare-Behavioral Health from Neuro-Psychological Services. Added References for MCO Amendment 11-Section 8.0 Utilization Management, Code of Federal Regulations 42 CFR 438 & 441.	04/25/19
Ad Hoc Review	Added new verbiage from Contract Amendment 16 Section 6.1.16.	05/16/19
Ad Hoc Review	Changed RFP to Emergency Contract Added new verbiage from Emergency Contract Section 6.1.2, 6.27.3, 6.1.15 Grammatical changes Added in-network or out of network to Second Opinions Added Emergency Contract RFP references to Moral or Religious Objections Removed Behavioral Health Services and listed out Specialized Behavioral Health Services	02/25/20
Ad Hoc Review	Added new verbiage from Emergency Contract Section 6.1.11.1-6.1.11.2, 6.1.14, 6.4.2-6.4.3, 6.18.1 6.24.1, & 6.26.2 Grammatical changes Removed no authorization required for MST and CI Removed the transportation vendor name	03/25/21
Ad Hoc Review	Changed Medical Management to PHCO Added with the exception of PCS for DOJ members to the PCS section Added crisis services, IPS and PCS-DOJ	06/29/22
Ad Hoc Review	Changed Member to Enrollee Updated contract references to Model Contract Reformatted to new policy template	12/01/22
Ad Hoc Review	Updated the definition of medically necessary services and language in the policy section to align with the contract; updated the footer	02/09/2023

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.