Government Business Division
Policies and Procedures

Section (Primary Department)	SUBJECT (Document Title)
Health Care Management	**Out-of-Area, Out-of-Network Care – LA**

Effective Date	Date of Last Review	Date of Last Revision	Dept. Approval Date
February 26, 1996	April 23, 2019~~January 29, 2020~~	~~May 30, 2018~~January 29, 2020	~~April 23, 2019~~January 29, 2020
Department Approval/Signature :			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid**	☐ Arkansas	☐ Indiana	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☐ California	☐ Iowa	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Kentucky	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☒ Louisiana	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Maryland	☐ North Carolina	☐ Wisconsin
	☐ Georgia	☐ Minnesota	☐ South Carolina	☐ West Virginia

POLICY:

To provide a mechanism for ~~eligible~~ members to receive adequate and timely ~~needed~~ medically necessary care when ~~such care is medically necessary and~~ the member is not able ~~within the network service area~~ to access a participating provider within the service area or the member needs a service that is not offered within the network.

Healthy Blue ensures appropriate provider choice within the network and coordination with licensed, qualified, clinically appropriate, out-of-network providers as needed for continuity of care. The ~~Healthy Blue~~ member handbook informs members of their rights, ~~in the member handbook. This includes~~ where and how to access services and providers, and any restrictions on the member's freedom of choice among providers.

~~Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet members' medical needs. If Healthy Blue is unable to provide the necessary services to a member within network, the plan must adequately and timely cover these services out of network. Healthy Blue shall ensure coordination with respect to authorization and payment issues in these circumstances. Healthy Blue may require prior authorization of out of network services, unless services are required to treat an emergency medical condition.~~

Healthy Blue ~~shall~~ assists members and providers in determining the need for services outside the network and refers members to appropriate service providers. ~~Healthy Blue refers m~~Members are referred to ~~out-of-network~~OON services and specialty care~~providers~~ (including tertiary care services) when there are no providers available within the network who have the appropriate training or expertise to meet the member's particular health needs. At the request of the member,

Healthy Blue will provide for a second opinion from a network provider, or arrange for the member to obtain one outside the network, at no cost to the member.

Network providers must be available within a reasonable distance and accessible within an appropriate timeframe to meet members' medical needs. If Healthy Blue is unable to provide necessary covered services within the network, it must adequately and timely cover these services out-of-network (OON). Healthy Blue ensures coordination with respect to authorization, payment, and travel distance (taking into account the availability of public transportation) in these circumstances (restriction and exception details are listed within this policy).

Healthy Blue ensures parity in determining access to OON providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to OON providers for medical/surgical benefits in accordance with 42 CFR §438.910(d)(3).

~~a)~~

~~Emergency Medical Services:~~

~~1) Healthy Blue shall provide that emergency services, including those for specialized behavioral health, be rendered without the requirement of prior authorization of any kind. The plan must cover and pay for emergency services regardless of whether the provider that furnishes the emergency services has a contract with Healthy Blue.~~

~~2) All members are advised of the provisions governing in-and out-of-service area use of emergency services.~~

~~3) Members in need of emergency medical or behavioral health services will be instructed to seek help from the nearest emergency medical provider, regardless of network participation.~~

~~Family Planning Services:~~

~~Members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the health plan's provider network without any restrictions.~~

~~1) The out-of-network Medicaid enrolled family planning services provider shall bill Healthy Blue and be reimbursed no less than the fee-for-service rate in effect on the date of service.~~

~~1) No additional reimbursements shall be made to Healthy Blue for members who elect to receive family planning services outside the network.~~

~~1) Members should be encouraged to receive family planning services through Healthy Blue's network of providers to ensure continuity and coordination of total care.~~

~~Care Coordination, Continuity of Care, and Care Transition:~~

~~Healthy Blue maintains effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to members. The plan~~

coordinates the delivery of core benefits and services with services that are reimbursed on a fee-for-service basis by LDH, provided by LDH's dental benefit program manager, or provided by community and social support providers. Healthy Blue makes referrals and coordinates care with behavioral health and primary care providers and agencies that promote continuity, as well as, cost-effectiveness of care. Healthy Blue ensures member appropriate provider choice within the network and interaction with providers outside the network.

Healthy Blue is responsible for:

0) The coordination and continuity of care of healthcare services for all members;
0) Ensuring a best effort is made to conduct an initial screening of new member's needs within ninety (90) days of their enrollment date, and that each member has an ongoing source of preventive and primary care appropriate to their needs;
0) Ensuring each member is provided with information on how to contact the person designated to coordinate the services the member accesses;
0) Coordinating with community resources, state agencies, and Local Governing Entities (LGEs) for the provision of Medicaid services;
0) Coordinating with the Office of Citizens with Developmental Disabilities for the behavioral health needs of the I/DD co-occurring population;
0) Coordinating care for in-network and out-of-network services, including specialty care services;
0) Coordination of Healthy Blue provided services with services the member may receive from other health care providers;
0) Coordinating with the court system and state child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed;
0) Providing active assistance to members receiving treatment for chronic and acute medical conditions or behavioral health conditions to transition to another provider when their current provider has terminated participation with Healthy Blue. The health plan shall provide continuation of such services for up to ninety (90) calendar days or until the member is reasonably transferred without interruption of care, whichever is less;

Continuity of Care for Pregnant Women:

0) In the event a member entering the plan is receiving medically necessary covered services in addition to, or other than, prenatal services the day before enrollment, Healthy Blue shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers.
0) Healthy Blue shall provide continuation of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less.
0) The plan may require prior authorization for continuation of the services beyond thirty (30) calendar days, however is prohibited from denying authorization solely on the basis that the provider is non-contract provider.

0) In the event a member entering the plan is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment, Healthy Blue shall 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 Healthy Blue can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health.
0) In the event a member entering the plan is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment, Healthy Blue shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract 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.
0) Healthy Blue shall ensure that the member is held harmless by the provider for the costs of medically necessary core benefits and services.

Continuity of Care for Individuals with Special Health Care Needs:

0) In the event a Medicaid or CHIP eligible entering the plan is receiving medically necessary covered services, the day before enrollment, Healthy Blue shall provide continuation/coordination of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less.
0) Healthy Blue may require prior authorization for continuation of the services beyond thirty (30) calendar days; however is prohibited from denying authorization solely on the basis that the provider is non-contract provider.

Continuity for DME, Prosthetics, Orthotics, and Certain Supplies:

0) In the event a Medicaid member entering the plan is receiving Medicaid covered durable medical equipment, prosthetics, orthotics, and certain supplies services the day before enrollment, whether such services were provided by another MCO or Medicaid fee-for-service, Healthy Blue shall be responsible for the costs of continuation of these services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. Healthy Blue shall provide continuation of such services for up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less.
0) Healthy Blue must honor any prior authorization for durable medical equipment, prosthetics, orthotics and certain supplies services issued while the member was enrolled in another MCO or the Medicaid fee-for-service program for a period of ninety (90) calendar days after the member's enrollment.

Continuity of Care for Pharmacy Services:

0) Healthy Blue's transition of care program ensures members can continue treatment of maintenance medications for at least sixty (60) days after launch of pharmacy services, enrollment, or switching from one plan to another.
0) Healthy Blue shall continue any treatment of antidepressants and antipsychotics for at least ninety (90) days after enrollment. Additionally, a member that is, at the time of enrollment, receiving a prescription drug that is not on the Formulary or PDL shall be permitted to continue to receive that prescription drug if medically necessary for at least sixty (60) days.
0) Healthy Blue shall continue the behavioral health therapeutic classes (including long-acting injectable antipsychotics), and other medication assisted treatment (including Suboxone and naloxone) prescribed in a state mental health treatment facility for at least ninety (90) days after the facility discharges the enrollee, unless Healthy Blue's psychiatrist, in consultation and agreement with the facility's prescribing physician, determines that the medications are not medically necessary or potentially harmful to the member.

Continuity Behavioral Health Care:

0) Healthy Blue shall not deny continuation of residential treatment (e.g., TGH or PRTF) for failure to meet medical necessity unless the plan can provide the service through an in-network or out-of-network provider for a lower level of care.
0) Healthy Blue shall ensure parity in determining access to out of network providers for mental health or substance use disorder benefits that are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits.
0) If shortages in provider network sufficiency are identified by LDH, Healthy Blue shall conduct outreach efforts, and take necessary actions to assure member access to medically necessary behavioral health services.
0) Healthy Blue shall execute an ad hoc or single case agreement when a clinical need or a specialized behavioral health service is identified for a member and no network provider is available to meet that particular need. In such cases, all transportation necessary to receive necessary services will be provided and reimbursed, including meals and lodging as appropriate.
0) Healthy Blue shall report the number of out-of-state placements as specified by LDH. LDH may require the plan to take corrective action in the event LDH determines the rate of out of state placements to be excessive.

Non-Emergent Medical Transportation (NEMT) Services:

1) Healthy Blue must have an established process for coordinating medically necessary long distance travel for members who require covered Medicaid state plan services out of state. This may include air travel, lodging, and reimbursement for meals, as supported by medical necessity.
1) Other primary private insurance coverage must not impede a member's ability to receive transportation benefits to and from services covered by Medicaid as a secondary payer. If

the private insurer has approved out-of-state services that are covered by Medicaid, the MCO must provide transportation, meals and lodging as specified in this section.

1) Healthy Blue may require prior authorization and/or scheduling of NEMT and may require documentation to verify coverage of medical services by the primary insurer prior to approval.

Continuity of Care for Indian Members:

- Healthy Blue shall demonstrate that there are sufficient Indian Health Care Providers (IHCPs) participating in the provider network to ensure timely access to services available under the contract from such providers for Indian members who are eligible to receive services.

1) The IHCPs, whether participating in the network or not, shall be paid for covered services provided to Indian members who are eligible to receive services from such providers.
1) Healthy Blue shall permit Indian members to obtain services covered under the contract from out-of-network IHCPs from whom the member is otherwise eligible to receive such services.
1) Where timely access to covered services cannot be ensured due to few or no IHCPs, Healthy Blue will be considered to have met requirements if:
) Indian members are permitted by Healthy Blue to access out-of-state IHCPs; or
) If this circumstance is deemed to be good cause for disenrollment from the State's Managed Care Program in accordance with 42 CFR §438.56(c).
1) Healthy Blue shall permit an out-of-network IHCP to refer an Indian member to a network provider.

Healthy Blue provides active assistance to members when transitioning to another MCO or to Medicaid FFS. Care transition guidelines are as follows:

2) The receiving plan shall be responsible for the provision of medically necessary services covered under the Contract that are required for the member during the transition period (i.e. prenatal care, acute care, etc.).
2) The transition period shall not exceed thirty (30) calendar days from the effective date of the member's enrollment in the receiving plan.
2) If a member is to be transferred between plans but is hospitalized at the time, the transfer shall be effective for the date of enrollment into the receiving plan. However, the relinquishing plan is responsible for the member's hospitalization until the member is discharged. The receiving Health Plan is responsible for all other care.
) In the event that the relinquishing plan's contract is terminated prior to the member's discharge, responsibility for the remainder of the hospitalization charges shall revert to the receiving plan, effective at 12:01 am on the day after the prior plan's contract ends.
2) Transfer of records shall not interfere or cause delay in the provision of services to the member.
2) Healthy Blue shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the plan, regardless of whether

such services are provided by an in-network or out-of-network provider, however, Healthy Blue may require prior authorization of services beyond thirty (30) calendar days.

3) During transition Healthy Blue is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first 30 days of a newly enrolled member's linkage to the plan.

Special consideration shall be given to, but not limited to, the following:

) Members with significant conditions or treatments such as enteral feedings, oxygen, wound care, and ventilators, medical supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition;

) Members who have received prior authorization for services such as scheduled surgeries, post-surgical follow up visits, therapies to be provided after transition or out-of-area specialty services;

) Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the NICU after birth; and

a) Members with significant medical conditions such as a high-risk pregnancy or pregnancy within the last thirty (30) days, the need for organ or tissue transplantation, chronic illness resulting in hospitalization.

4) When relinquishing members, Healthy Blue is responsible for timely notification to the receiving plan regarding pertinent information related to any special needs of transitioning members.

4) When receiving a transitioning member with special needs, the plan is responsible to coordinate care with the relinquishing plan so services are not interrupted, and for providing the new member with plan and service information, emergency numbers and instructions on how to obtain services.

Reimbursement to Out-of-Network Providers:

0) A provider must be enrolled in the Medicaid Program and meet the provider qualifications at the time service is rendered to be eligible to receive reimbursement through the Louisiana Medicaid Program.

0) Healthy Blue shall make payment for covered emergency and post-stabilization services that are furnished by out of network providers. Healthy Blue shall reimburse providers one hundred percent (100%) of the Medicaid rate for emergency services. Reimbursement to out-of-network providers for the provision of emergency services shall be no more than the Medicaid rate.

0) Emergency ancillary services rendered by non-network providers in a hospital setting shall be reimbursed at the published Medicaid fee schedule in effect on the date of service.

0) For services that do not meet the definition of emergency services, Healthy Blue is not required to reimburse more than ninety (90%) of the published Medicaid rate in effect on the date of service to out-of-network providers to whom they have made at least three (3) documented attempts to include the provider in their network.

~~0) Healthy Blue shall compensate, at a minimum, ninety percent (90%) of the Medicaid fee-for-service rate in effect for each service coded as a primary care service rendered to a newborn member within thirty days of the member's birth regardless of whether the provider rendering the services is contracted with the plan, but subject to the same requirements as a contracted provider.~~

~~0) If Healthy Blue is unable to contract with a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), the plan is not required to reimburse that FQHC or RHC without prior approval for out-of-network services unless:~~

~~) The medically necessary services are required to treat an emergency medical condition; or~~

~~) FQHC/RHC services are not available through at least one MCO within LDH's established distance travel standards.~~

~~) Healthy Blue may stipulate that reimbursement will be contingent upon receiving a clean claim and all the medical information required to update the member's medical record.~~

~~Payment for items or services will not be made to any entity located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories (Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa).~~

DEFINITIONS:

** Denotes terms for which Healthy Blue must use the State-developed definition.*

Emergency Services – Covered inpatient and outpatient services that are as follows: (a) furnished by a provider that is qualified to furnish these services under 42 CFR §438.114(a) and §1932(b)(2) of the Social Security Act; and (b) ~~that are~~ needed to screen, evaluate, and/or stabilize an emergency medical condition. ~~Services defined as such under Section 1867 (e) of the Social Security Act ("anti-dumping provisions").~~ If an emergency medical condition exists, Healthy Blue is obligated to pay for the emergency service. Coverage of emergency services must not include any prior authorization requirements and the "prudent layperson" standard shall apply to both in-network~~plan~~ and out-of-network~~plan~~ coverage.

~~**Family Planning Services** – Services that include examinations and assessments, diagnostic procedures, health education, and counseling services related to alternative birth control and prevention as prescribed and rendered by physicians, hospitals, clinics and pharmacies.~~

Fee-for-Service (FFS) Rate – A method of provider reimbursement based on payments for specific services rendered. For MCO covered services, the reimbursement rate published on www.lamedicaid.com or on the weekly procedure file sent to Healthy Blue by the Fiscal

Intermediary (FI), or its equivalent, whichever is most current on the date of service. Also referred to as the "Medicaid rate."

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

~~**Network** – May be defined as a group of participating providers linked through Provider Network Agreements to Healthy Blue to supply a range of primary and acute health care services. Also referred to as Provider Network.~~

~~**Network Adequacy –** Refers to the network of health care providers for Healthy Blue that is sufficient in numbers and types of providers and facilities to ensure that all services are accessible to members without unreasonable delay. Adequacy is determined by a number of factors, including but not limited to, provider patient ratios; geographic accessibility and travel distance; waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments and hours of provider operations. Network Adequacy will be assessed on contracted network providers excluding single case agreements unless otherwise approved by LDH.~~

Network Provider – An appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and ~~S~~subcontractors~~,~~ that has a provider agreement~~contract~~ with Healthy Blue for the delivery of MCO covered services to Healthy Blue's enrollees~~core benefits and services to members~~.

~~**Non-Participating Provider –** A provider that does not have a signed network provider contract or agreement.~~

Out-of-Network (OON) Provider – ~~means a~~An appropriately licensed individual, facility, agency, institution, organization, or other entity that has not entered into a contract with Healthy Blue for the delivery of MCO covered services to Healthy Blue's enrollees~~members~~.

Out-of-Service Area (OOSA) – Care rendered by a non-participating provider outside of the ~~counties~~parishes or jurisdictions where Healthy Blue~~the health plan~~ has been licensed by the ~~S~~state or ~~F~~federal (CMS) to cover members; b~~.~~eyond the contiguous or bordering counties of Louisiana's adjacent states.

~~**Participating Provider –** A provider that has a signed network provider agreement with a plan.~~

~~**Plan –** An individual or group that provides, or pays the cost of, medical care.~~

~~**Prior Authorization –** The process of determining medical necessity for specific services before they are rendered. Also referred to as preauthorization, prior approval, or precertification.~~

~~**Provider –** Either (1) for the fee-for-service program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the MCO Program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers services.~~

~~**Referral Services –** Health care services provided to members to both in-and out-of-network when ordered and approved by Healthy Blue, including, but not limited to in-network specialty care and out-of-network services which are covered under the Louisiana Medicaid State Plan.~~

Service Area – The designated area in which Healthy Blue~~the plan~~ is authorized to furnish ~~core benefits and~~ covered services to enrollees. The service area is the entire state of Louisiana.

Service Authorization – A utilization management activity that includes pre-, concurrent, or post-review of a service by a qualified health professional to authorize, partially deny, or deny the payment of a service, including a service requested by the member. Service authorization activities consistently apply review criteria.

Single Case Agreement (SCA) – An agreement between ~~the Company~~Healthy Blue and an out-of-network (OON) provider to render specific services at an agreed upon rate of reimbursement.

Utilization Review (UR) – Evaluation of the clinical necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings, and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective review.

PROCEDURE:

Out-of-Service Area (OOSA)Care/Out-of-Network (OON) Care

(**NOTE:** *OOSA/OON emergent care does not require precertification. See additional exceptions to requirements below.n)*

1) The Licensed UR nurse receives an Upon receipt of an OOSA/OON request, the member's eligibility is verified.t.

1) The Licensed UR nurse verifies member eligibility.

1) A licensed The Licensed UR associatenurse verifies the servicing and ordering providers areis enrolled to participate in the Louisiana Medicaid Program, and .

1) The Licensed UR nurse checks the appropriate state and national databases to determine if the the OONnon-par providers havees any sanctions on theirhis or her license.

d)2) At a minimum the The following websites websites shall be searched:

a) Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE);
b) The System of Award Management (SAM);
c) Louisiana Adverse Actions List Search (LAALS); and
d) Other applicable sites as may be determined by the Louisiana Department of Health (LDH).

e) Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE);
f) The System of Award Management (SAM); and
g) Louisiana Adverse Actions List Search.

3) If a sanction exists, the Licensed UR associatenurse informs the requestor that the service cannot be approved.

a) If a the provider requestor has additional questions, they are Licensed UR nurse informeds the provider to contact the Provider Relations (PR) Department. As necessary, the Licensed UR nurse assists the member with selecting a new provider. The Licensed UR associate nurse generates a contact log which is routed to the Provider Relations DepartmentPR as a notification of the impending provider contact.

h)b) As necessary, the UR associate assists the member with selecting a new provider.

2)4) If no sanctions exist, tThe Llicensed UR associatenurse reviews the request and the circumstances to for medical necessity, appropriateness, and to determine if the member's condition meets the OOSA/OON guidelines. (rRefer to *Regulatory SharePoint Site for Out-of-Area, Out-of-Country Benefit Coverage* and *Continuation of Care Requirement Enrollment Grids*[WJL1]).

5) If the service is offered in-network and is non-emergent in nature, the Licensed UR nurse associate attempts redirection to an in-network provider/and or facility, as applicable.

a) If the requestor accepts redirection to an in-network provider, the request is authorized as medically necessary within the applicable decision timeframe.

a)b) If the requestor declines redirection to theean in-network provider option, the OON Licensed UR nurse documents the information in the utilization management system and routes the requestcase is routed to the Medical Director (or appropriate practitioner)

forwho makes a determination. within the appropriate timeframe concerning the request. (Refer to *Pre-Certification of Requested Services* Procedures for appropriate timeframes)

3)6) The Medical Director (or appropriate practitioner) reviewss the request and circumstances to and renders a determination within the applicable decision timeframe regarding the OOSA/OON request. All OOSA/OON requests are determined and authorized by a Medical Director.

3) The Licensed UR nurse performs the following actions: If an approval determination is made:

b)7) Approval: Updates the case, per documentation standards, and notifies the requesting provider and/or facility of the determination if applicable, and routes the case to the health plan Provider Relations Department to complete the SCA process, if applicable.

a) The licensed UR associate completes the authorization, updates the case per documentation standards, and notifies the requesting provider of the determination.

b) Upon request by the OON provider, the approval is routed to the health plan SCA specialist for rate negotiation and completion of an SCA. If the OON provider accepts the Medicaid FFS or standard OON rate, there is no need for an SCA (refer to *Out-of-Network Authorization Process*).

) If a If applicable, updates the case with the appropriate information to inform the Claims Analyst, of the pre-certification status.

8) dDenial determination is rendered:

d)a) The licensed UR associate completes the Updates the case, per documentation standards, and initiates the denial process (refer to *Health Care Management Denial – LA*). which includes the rights of an appeal to the member and the provider.

e)b) As appropriate, aDeveloping a strategy is developed to coordinate orthe transition care of the member to an in-network or participating provider; this may include a referral to Case Management.plan provider once the member is stable or the care requires long-term treatment that is available from a participating provider.

9) If the member has moved OOSA, the disenrollment process is initiated per health plan requirements.

3) The National Customer Care (NCC) Department is notified to update the member's address in the appropriate systems.

g)a) The member must notify the SState regarding their new address.

Reimbursement to OON Providers

1) Prior authorization of out-of-network services may be required, unless services are necessary to treat an emergency medical condition. Healthy Blue shall make payment for covered emergency and post-stabilization services that are furnished to members by providers that have no arrangements with the Healthy Blue for the provision of such services (refer to *Emergency and Post-Stabilization Services – LA*). Healthy Blue shall reimburse the provider one hundred percent (100%) of the FFS rate for emergency services. In compliance with Section 6085 of the Deficit Reduction Act (DRA) of 2005, reimbursement to OON providers for the provision of emergency services shall be no more than the FFS rate.

2) For services that do not meet the definition of emergency services, prior authorization may required. Healthy Blue is not required to reimburse more than ninety percent (90%) of the published FFS rate in effect on the date of service to OON providers to whom they have made at least three (3) documented attempts to include in their network (except as noted in the Contract for Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Indian Health Service (IHS) providers).
3) To ensure Mental Health Rehabilitation (MHR) providers meet the minimum state requirements to provide services, Healthy Blue shall not make payment for Community Psychiatric Support Treatment (CPST) or Psychosocial Rehabilitation (PSR) services that are furnished to members by providers that are OON. Healthy Blue may make payment for CPST or PSR services only to those providers who are credentialed and participating in Healthy Blue's provider network for the provision of such services, or who are licensed and accredited and have an SCA for provision of such services.
4) In order to receive reimbursement, providers must ~~be enrolled~~ [WM2] ~~to participate in Louisiana Medicaid,~~ meet [RJM3] all licensing and/or certification requirements inherent to his/her profession and comply with all other requirements in accordance with the federal and state laws and Bureau of Health Services Financing (BHSF) policies.
5) Healthy Blue shall not pay claims to or execute contracts with individuals or groups of providers who have been excluded from participation in federal health care programs or state funded health care programs.
6) Healthy Blue shall not remit payment for services provided under the Contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories.

EXCEPTIONS:

Exceptions to Access Requirements

1) Healthy Blue shall ensure primary care provider (PCP) services, obstetrics/gynecology, hospital services, pharmacy, behavioral health and other services identified in the Contract are available from network providers within the specified travel distance and time requirements from the enrollee's home. Exceptions, if any, to these time and distance standards shall be at the discretion of LDH and only considered based on the prevailing community standard.
   a) Healthy Blue must submit any requests for exceptions for time, distance, or appointment accessibility standards in writing to LDH for approval. Such requests must be in a format specified by LDH and include data on the local provider population available to the non-Medicaid population.
   b) Healthy Blue shall allow a member the option of choosing to travel further than established access standards in order to access a preferred provider. The member shall be responsible for travel arrangements and costs unless there is not a qualified provider meeting the accessibility standards within the provider network.

2) As permitted by state law, telemedicine[WM4][RJM5] may be used by specialists to facilitate access to MCO covered services by licensed professionals to augment the network. Any service provided via telemedicine must be medically necessary, and the procedure individualized, specific, and consistent with symptoms or confirmed diagnosis of an illness or injury under treatment, and not in excess of the member's needs.
   a) If Healthy Blue intends to utilize telemedicine to meet network adequacy requirements, the telemedicine utilization must be approved by LDH for this purpose.
3) Healthy Blue shall permit Indian enrollees to obtain MCO covered services from OON Indian Health Care Providers (IHCPs) from whom the member is otherwise eligible to receive such services. Where timely access to covered services cannot be ensured due to few or no IHCPs, Healthy may consider permitting Indian enrollees to access out-of-state IHCPs. OON IHCPs may refer an Indian member to a network provider.
4) Healthy Blue ensures members have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the provider network without any restrictions as specified in 42 CFR §431.51(b)(2).
   a) The OON Medicaid-enrolled family planning services provider shall bill Healthy Blue and be reimbursed no less than the FFS rate in effect on the date of service.
   b) Healthy Blue encourage its members to receive family planning services through network of providers to ensure continuity and coordination of the member's total care.
   c) Authorization or referral shall not be required for family planning services and the treatment of sexually transmitted infections (STIs).

Exceptions to Authorization Requirements

1) Healthy Blue shall not require service authorization for emergency services or post-stabilization services as described in the Contract, whether provided by an in-network or OON provider.
2) Healthy Blue shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.
3) Healthy Blue shall not require service authorization or referral for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program screening services.
4) Healthy Blue shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the health plan, regardless of whether such services are provided by an in-network or OON provider, however, prior authorization of services may be required beyond thirty (30) calendar days.
5) Healthy Blue is prohibited from denying prior authorization solely on the basis of the provider being an OON provider for the first thirty (30) days of a newly enrolled member's linkage to the plan.
6) Healthy Blue shall not require a primary care physician (PCP) referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the plan for routine and preventive women's healthcare services and prenatal care.
7) Healthy Blue shall not require a PCP referral for in-network eye care and vision services.

8) Healthy Blue may require notification by the provider of obstetrical care at the time of the first visit of the pregnancy.
9) Healthy Blue may require notification by the provider of obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery. Healthy Blue is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of obstetrical admission exceeding forty-eight (48) hours after vaginal delivery. In this case, only the portion of the claim related to the inpatient stay beyond forty-eight (48) hours is denied.
10) Healthy Blue may require notification by the provider of obstetrical admissions exceeding ninety-six (96) hours after Caesarean section. Healthy Blue is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of obstetrical admission exceeding ninety-six (96) hours after Caesarean section. In this case, only the portion of the claim related to the inpatient stay beyond ninety-six (96) hours is denied.
11) Healthy Blue may require notification by the provider of inpatient emergency admissions within one (1) business day of admission. Healthy Blue is allowed to deny a claim for payment based solely on lack of notification of inpatient emergency admission, if the provider does not notify of the inpatient emergency admission within one (1) business day of admission.
12) Healthy Blue shall not deny continuation of higher-level services (e.g., inpatient hospital or residential treatment) for failure to meet medical necessity unless the required service can be provided through an in-network or OON provider at a lower level of care.

Refer to *Non-Covered and Cost-Effective Alternative Services – LA* for information regarding excluded and non-covered services.

REFERENCES:

~~42 CFR Chapter IV Part 431~~
A04 Prescriptions for Out of Area Travel
Access to Behavioral Health Care
CFR Title 42
Clinical Criteria for Utilization Management Decisions – Core Process ~~– LA~~
Clinical Information for Utilization Review – LA
Concurrent Review (Telephonic and On-Site) – LA
Coordination of Care – LA
Continuity of Care ~~– Core Process~~ – LA

Emergency and Post-Stabilization Services ~~– Core Process~~ – LA
Louisiana State Contract
Medical Transportation – LA
~~Member Handbook~~Non-Covered and Cost-Effective Alternative Services – LA
~~Member Privacy Rights~~
Out-of-Network Authorization Process

Pre-cCertification of Requested Services – LACore Process
Provider Manual
Quality Improvement System for Managed Care 2.3.1.5 Enrollee Rights (Health and Human Services Guidelines for Assessing Improvement in Managed Care Delivery Systems)
Regulatory Services: Continuation of Care Requirements Enrollee Rights Grid
Regulatory Services: Member Moves Out of Service Area Grid
Regulatory Services: Out of Area/Out of the Country Coverage Grid
Retrospective Review – LA
Second Opinion
Telephonic Nurse Advice – Nurse HelpLine – McKesson

RESPONSIBLE DEPARTMENTS:

Primary Department: –
Health Care Management

Secondary Department(s): – Behavioral Health,
National Customer Care Organization, Department
Provider Relations – Health Plan

REVISION HISTORY:

Review Date	Changes
06/01/2015	• New. Created LA-specific version of corporate document.
06/14/2016	• Annual review • National Provider Communications removed as secondary department • Definitions placed in alphabetical order • Policy section under number 3 updated • References section updated
07/24/2017	• For annual review • References placed in alphabetical order
05/30/2018	• Off-cycle/Eearly annual review • Policy revised to reflect current contract language
04/23/2019	• For annual review • No changes
01/29/2020	• Off-cycle review for new LA Emergency Contract • Edits within policy, definitions, and procedure sections • References updated • Behavioral Health added as a Secondary Department

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management	**Out-of-Area, Out-of-Network Care – LA**