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Quick Reference Guide to Important Addresses and Phone Numbers

Health Plan Information
Louisiana Health Cooperative, Inc.
3445 N. Causeway Blvd., Suite 800
Metairie, Louisiana 70002

www.myLAHC.org

Claims Addresses
All completed paper claim forms should be forwarded to the following addresses for processing:

PHCS:
PHCS
PO Box 21823
Eagan, MN 55121

Verity/Other:
GRI
P.O. Box 100043
Duluth, GA 30096-9343

Electronic Claims Submission
PHCS: EDI claims to Electronic Payer ID: 28680

Provider Network Administration
Participation/Contracting/Credentialing Questions: (504) 383-7456

Provider Relations: (888) 620-1297
Appeals and Grievances/ Provider Dispute Resolution

Louisiana Health Cooperative, Inc.
Appeals and Grievance Department
3445 N. Causeway Blvd, Suite 800
Metairie, La 70002

(504) 322-4350 or
Toll-free (855) 889-8806
Toll-free fax (855) 792-0455
Fax (504) 826-8160
Section 1: Welcome to Louisiana Health Cooperative

Louisiana Health Cooperative, Inc. (LAHC) is a non-profit, member-governed health plan that offers insurance coverage to individuals, families and small employers via HMO and POS products. LAHC is known as Consumer Operated and Oriented Plan, or “CO-OP”.

Mission and Vision

LAHC’s mission is to promote community health and well-being by engaging the members and providers it serves in the valued delivery of high quality, integrated health care services.

In the LAHC community:

- Members are responsible
- Providers are accountable
- Care is affordable
- Choice is available

Purpose of this Manual

This Manual is intended for providers who have contracted with Louisiana Health Cooperative to deliver quality health care services to our members enrolled in a Health Maintenance Organization (HMO) or Point of Service (POS) Benefit Plan.

This Manual serves as a guide to you and your staff to comply with the policies and procedures governing the administration of our Program and is an extension of and supplements the provider participation contract you entered into with Louisiana Health Cooperative (Agreement). This Manual is available online at www.myLAHC.org/Provider/ProviderManuals. A paper copy is available at no charge to providers upon request.

In accordance with your Agreement, participating providers must abide by all applicable provisions of this Manual, as may be modified from time to time upon notice. Louisiana Health Cooperative may change this Manual to reflect changes in our policies and procedures and all revisions shall become binding 30 days after LAHC notifies you, or such lesser time in compliance with laws, government payor contracts, or accreditation requirements.

We will notify you of changes to this Manual in the form of Provider Bulletins or Manual updates, which shall be provided to you by mail, facsimile, or other electronic means. Louisiana Health Cooperative may release Provider Bulletins that are state-specific and may override the policies and procedures in this Manual for that specific state only.
Louisiana Health Cooperative, Inc. (LAHC)

As a CO-OP organization, LAHC’s focus is on developing programs intended to improve the quality of health care delivered to members, such as:

- Preventive programs offered with early health screenings;
- Focusing on health outcomes based on sound clinical evidence;
- Ongoing measurement and comparison of performance to clinical quality standards;
- A comprehensive medical network;
- Coordinated care programs;
- Opportunities for members to participate in their care.

Our Products

Our products are designed to offer enhanced benefits to our members as well as cost-sharing alternatives. Our products are offered in selected markets to allow flexibility and offer a distinct set of benefits to fit member needs in each area. Please refer to the website at www.myLAHC.org for more information. Below is a list of our products that are subject to change.

- **Health Maintenance Organization (HMO)** – All services must be provided within the Louisiana Health Cooperative, Inc. network unless an emergency or urgent need for care arises, or such service is not available in-network. Some services require prior authorization by Louisiana Health Cooperative, Inc. or its designee.

- **Point of Service (POS)** - The point-of-service (POS) benefit allows members to access most medically necessary services from non-network providers. Members will pay more out-of-pocket to access services outside the network when they use their POS benefit.

Provider Services

Providers may contact the appropriate departments at Louisiana Health Cooperative by referring to the *Quick Reference Guides* on Louisiana Health Cooperative website at www.myLAHC.org. In addition, our Provider Relations representatives are available to assist you. Please contact our office for assistance.

Website Resources

Louisiana Health Cooperative’s website, www.myLAHC.org, intends to offer a variety of tools to assist providers and their staff.

Available resources may include:

- Provider Manuals;
- Quick Reference Guides;
- Clinical Practice Guidelines;
- Clinical Coverage Guidelines;
- Forms and documents;
- Pharmacy and provider lookup (directories);
• Authorization look-up tool;
• Training materials and job aids;
• Newsletters;
• Member rights and responsibilities; and
• Privacy statement and notice of privacy practices.

**Secure Provider Portal - Benefits of Registering**

Our secure online Provider Portal offers immediate access to an assortment of useful tools. Providers can create unlimited individual sub-accounts for staff members, allowing for separate billing and medical accounts.

All providers who create a login and password using their Provider Identification (Provider ID) number have access to the following features:

• **Claims submission status and inquiry;**
• **Member eligibility and co-payment information;**
• **Authorization requests: Pharmacy services;**
• **Reports;**
• **Provider news;** and
• **Personal inbox.**
Section 2: Provider and Member Administrative Guidelines

Provider Administrative Overview

In accordance with generally accepted professional standards, participating providers must:

- Meet the requirements of all applicable state and federal laws and regulations, including without limitation, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973;
- Agree to cooperate with Louisiana Health Cooperative in its efforts to monitor compliance with its HMO contract(s) and/or POS rules and regulations, and assist Louisiana Health Cooperative in complying with corrective action plans necessary to comply with such rules and regulations;
- Retain all agreements, books, documents, papers, and medical records related to the provision of services to Louisiana Health Cooperative members as required by state and federal laws;
- Provide Covered Services in a manner consistent with professionally recognized standards of health care [42 C.F.R. § 422.504(a)(3)(iii)];
- Use physician extenders appropriately. Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNPs) should provide direct member care within the scope or practice established by the rules and regulations of the state and Louisiana Health Cooperative guidelines;
- Assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations;
- Clearly identify their title (examples: M.D., D.O., ARNP, PA) to members and to other health care professionals;
- Honor at all times any member request to be seen by a physician rather than a physician extender;
- Administer treatment for any member in need of health care services they provide;
- Respond within the identified timeframe to Louisiana Health Cooperative requests for medical records in order to comply with regulatory requirements;
- Maintain accurate medical records and adhere to all Louisiana Health Cooperative policies governing the content and confidentiality of medical records as outlined in Section 3: Quality Improvement and Section 8: Compliance;
- Allow Louisiana Health Cooperative to use provider performance data;
- Ensure that:
  - all employed physicians and other health care practitioners and providers comply with the terms and conditions of the Agreement; to the extent the physician maintains written agreements with employed physicians and other health care practitioners and providers, such agreements contain similar provisions to the Agreement; and the physician maintains written agreements with all contracted physicians or other health care practitioners and providers, which agreements contain similar provisions to the Agreement;
• Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene; Communicate timely clinical information between providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to Louisiana Health Cooperative, the member, or the requesting party at no charge, unless otherwise agreed;
• Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis, and expected outcome of recommended medical, surgical, and medication regimen;
• Not discriminate in any manner Louisiana Health Cooperative members;
• Not deny, limit or condition the furnishing of treatment to any Louisiana Health Cooperative member on the basis of any factor that is related to health status, including, but not limited to the following:
  ▪ medical condition, including mental as well as physical illness;
  ▪ claims experience;
  ▪ receipt of health care;
  ▪ medical history;
  ▪ genetic information;
  ▪ evidence of insurability; including conditions arising out of acts of domestic violence; or
  ▪ disability;
• Freely communicate with and advise members regarding the diagnosis of the member’s condition and advocate on the member’s behalf for the member’s health status, medical care, and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services;
• Identify members who are in need of services related to domestic violence, smoking cessation or substance abuse. If indicated, providers must refer members to Louisiana Health Cooperative-sponsored or community-based programs; and
• Must document the referral to Louisiana Health Cooperative-sponsored or community-based programs in the member’s medical record and provide the appropriate follow-up to ensure the member accessed the services.

**Advance Directive**

Members have the right to control decisions relating to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life. Advance Directives may differ among states.

Each member (age 18 years or older and of sound mind), should receive information regarding Advance Directives. These directives allow the member to designate another person to make medical decisions on the member’s behalf should the member become incapacitated.

Information regarding Advance Directives should be made available in provider offices and discussed with the members. Completed forms should be documented and filed in members’ medical records.
Providers shall not, as a condition of treatment, require a member to execute or waive an Advance Directive.

**Provider Billing and Address Changes**
Prior notice to your Provider Relations representative or Provider Services is required for any of the following changes:
- 1099 mailing address;
- Tax Identification Number (TIN) or Entity Affiliation (W-9 required);
- Group name or affiliation;
- Physical or billing address; and
- Telephone and fax number.

Failure to notify Louisiana Health Cooperative prior to these changes will result in a delay in claims processing and payment.

**Provider Termination**
In addition to the provider termination information included in the Agreement, you must adhere to the following terms:
- Any contracted provider must give at least 90 days prior written notice (180 days for a hospital) to Louisiana Health Cooperative before terminating your relationship with Louisiana Health Cooperative “without cause,” unless otherwise agreed to in writing. This ensures adequate notice may be given to Louisiana Health Cooperative members regarding your participation status with Louisiana Health Cooperative. Please refer to your Agreement for the details regarding the specific required days for providing termination notice, as you may be required by contract to give more notice than listed above; and
- Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month.

Please refer to *Section 6: Credentialing* of this Manual for specific guidelines regarding rights to appeal plan termination (if any).

Louisiana Health Cooperative will notify in writing all appropriate agencies and/or members prior to the termination effective date of a participating PCP, hospital, specialist or significant ancillary provider within the service area as required.

**Out-of-Area Member Transfers**
Providers should assist Louisiana Health Cooperative in arranging and accepting the transfer of members receiving care out of the service area if the transfer is considered medically acceptable by a Louisiana Health Cooperative provider and the out-of-network attending physician/provider.
Members with Special Health Care Needs

Members with special health care needs have one or more of the following conditions:

- Mental retardation or related conditions;
- Serious chronic illnesses such as Human Immunodeficiency Virus (HIV), schizophrenia or degenerative neurological disorders;
- Disabilities resulting from chronic illness such as arthritis, emphysema or diabetes; or
- Children and adults with certain environmental risk factors such as homelessness or family problems that may lead to the need for placement in foster care.

Providers, who render services to members with special health care needs, shall:

- Assess members and develop plans of care for those members determined to need courses of treatment or regular care;
- Coordinate treatment plans with members, family and/or specialists caring for members;
- Develop a plan of care that adheres to community standards and any applicable sponsoring government agency quality assurance and utilization review standards;
- Allow members needing courses of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as appropriate for the members’ conditions or needs;
- Coordinate with Louisiana Health Cooperative, if appropriate, to ensure that each member has an ongoing source of primary care appropriate to his or her needs, and a person or entity formally designated as primarily responsible for coordinating the health care services furnished;
- Coordinate services with other third party organizations to prevent duplication of services and share results on identification and assessment of the member’s needs; and
- Ensure the member’s privacy is protected as appropriate during the coordination process.

Access Standards

All providers must adhere to standards of timeliness for appointments and in-office waiting times. These standards take into consideration the immediacy of the member’s needs. Louisiana Health Cooperative shall monitor providers against the standards below to ensure members can obtain needed health services within acceptable appointment, in-office waiting times, and after-hours standards. Providers not in compliance with these standards will be required to implement corrective action.

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP – Urgent</td>
<td>&lt; 24 hours</td>
</tr>
<tr>
<td>PCP – Non-urgent</td>
<td>&lt; 1 week</td>
</tr>
<tr>
<td>PCP – Routine</td>
<td>&lt; 30 days</td>
</tr>
<tr>
<td>Specialist</td>
<td>&lt; 30 days</td>
</tr>
</tbody>
</table>

In-office wait times shall not exceed 30 minutes.
PCPs must provide or arrange for coverage of services, consultation, or approval for referrals 24 hours per day, seven days per week. To ensure access and availability, PCPs must provide one of the following:

- A 24-hour answering service that connects the member to someone who can render a clinical decision or reach the PCP;
- Answering system with option to page the physician for a return call within a maximum of 30 minutes; or
- An advice nurse with access to the PCP or on-call physician within a maximum of 30 minutes.

Please see Section 11: Behavioral Health for mental health and substance use access standards.

Responsibilities of Primary Care Providers
The following is a summary of responsibilities specific to PCPs who render services to Louisiana Health Cooperative members. Coordinate, monitor and supervise the delivery of primary care services to each member:

- See members for an initial office visit and assessment within the first 90 days of enrollment in Louisiana Health Cooperative;
- Assure members are aware of the availability of public transportation where applicable;
- Provide access to Louisiana Health Cooperative or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity. A related organization or entity is defined as having influence, ownership or control and either a financial relationship or a relationship for rendering services to the primary care office;
- Submit an encounter to Louisiana Health Cooperative for each visit where the provider sees the member or the member receives a Healthcare Effectiveness Data and Information Set (HEDIS®) service. For more information on encounters, refer to the Section 5: Claims in this Manual;
- Ensure members utilize network providers. If unable to locate a Louisiana Health Cooperative-participating provider for services required, contact our Clinical Care Integration Department for assistance. Refer to the Quick Reference Guides at www.myLAHC.org; and
- Comply with and participate in corrective action and performance improvement plan(s).

Primary Care Offices
PCPs provide comprehensive primary care services to Louisiana Health Cooperative members. Primary care offices participating in our provider network have access to the following Louisiana Health Cooperative resources:

- Support of our Provider Relations, Provider Services, Health Services, Marketing and Sales Departments;
- The tools and resources available on Louisiana Health Cooperative’s website at www.myLAHC.org, and
• Information on Louisiana Health Cooperative network providers for the purposes of referral management and discharge planning.

Closing of Provider Panel

When requesting closure of your panel to new and/or transferring Louisiana Health Cooperative members, PCPs must:

• Submit the request in writing at least 60 days (or such other period of time provided in the Agreement) prior to the effective date of closing the panel;
• Maintain the panel to all Louisiana Health Cooperative members who were provided services before the closing of the panel; and
• Submit written notice of the re-opening of the panel, including a specific effective date.

Covering Physicians/Providers

In the event that participating providers are temporarily unavailable to provide care or referral services to members, providers should make arrangements with another Louisiana Health Cooperative-contracted and credentialed provider to provide services on their behalf, unless there is an emergency.

Covering providers should be credentialed by Louisiana Health Cooperative, and are required to sign an agreement accepting the negotiated rate. For additional information, please refer to Section 6: Credentialing.

In non-emergency cases, should you have a covering physician/provider who is not contracted and credentialed with Louisiana Health Cooperative, contact Louisiana Health Cooperative for approval.

Assignment of Primary Care Provider

All HMO members will choose a PCP or one will be assigned to the member. To ensure quality and continuity of care, the PCP is responsible for arranging all of the member’s health care needs from providing primary care services to coordinating referrals to specialists and providers of ancillary or hospital services.

Termination of a Member

A Louisiana Health Cooperative provider may not seek or request to terminate his or her relationship with a member, or transfer a member to another provider of care, based upon the member’s medical condition, amount or variety of care required or the cost of covered services required by the member.

Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. In the event that a participating provider desires to terminate his or her relationship with a member, the provider should submit adequate documentation to support that although he or she has attempted to maintain a satisfactory provider and member relationship, the member’s non-compliance with treatment or
uncooperative behavior is impairing the ability to care for and treat the member effectively. The provider should adequately document in the member’s medical record evidence to support his or her efforts to develop and maintain a satisfactory provider and member relationship. If a satisfactory relationship cannot be established or maintained, the provider shall continue to provide medical care for the member until such time that written notification is received from Louisiana Health Cooperative stating, “The member has been transferred from the provider’s practice, and such transfer has occurred.”

The provider should complete a PCP Request for Transfer of Member form, attach supporting documentation and fax the form to our Provider Services Department. This form is on Louisiana Health Cooperative’s website at www.myLAHC.org.

**Domestic Violence and Substance Abuse Screening**
PCPs should identify indicators of substance abuse or domestic violence. Sample screening tools for domestic violence and substance abuse are located on Louisiana Health Cooperative’s website at https://www.myLAHC.org.

**Smoking Cessation**
PCPs should direct members who wish to quit smoking to call our Member Service Department and ask to be directed to the Case Management Department. A case manager will educate the member on national and community resources that offer assistance, as well as smoking cessation options available to the member through Louisiana Health Cooperative.

**Adult Health Screening**
An adult health screening should be performed by a provider to assess the health status of all Louisiana Health Cooperative members. The adult member should receive an appropriate assessment and intervention as indicated or upon request.

Please refer to the adult preventive health guidelines and the member physical screening tool, both located on Louisiana Health Cooperative’s website at www.myLAHC.org.

**Member Administrative Guidelines**

**Overview**
Louisiana Health Cooperative will make information available to members on the role of the PCP, how to obtain care, what to do in an emergency or urgent medical situation as well as their rights and responsibilities. Louisiana Health Cooperative will convey this information through various methods including an Evidence of Coverage booklet.
Enrollment
Louisiana Health Cooperative must obey laws that protect from discrimination or unfair treatment. Louisiana Health Cooperative does not discriminate based on a person’s race, disability, religion, sex, health, ethnicity, creed, age, or national origin.

Upon enrollment with Louisiana Health Cooperative, members are provided the following:

- Terms and conditions of enrollment;
- Description of Covered Services in-network and out-of-network (if applicable);
- Information about PCPs, such as location, telephone number and office hours;
- Information regarding “out-of-network” emergency services;
- Grievance and disenrollment procedures; and

Member Identification Cards
Member identification cards are intended to identify Louisiana Health Cooperative members, the type of plan they have, and facilitate their interactions with health care providers. Information found on the member identification card may include the member’s name, identification number, plan type, co-payment information, health plan contact information, and claims filing address. Possession of the member identification card does not guarantee eligibility or coverage. Providers are responsible for ascertaining the current eligibility of the cardholder.

Eligibility Verification
A member’s eligibility status can change at any time. Therefore, all providers should request and copy the member’s identification card, along with additional proof of identification such as a photo ID, and file them in the patient’s medical record.

Providers may do one of the following to verify eligibility:

- Access the Provider Portal at www.mylahc.org/providers
- Contact our Provider Services Department.

You will need your Provider ID number to access member eligibility through the avenues listed above. Verification is always based on the data available at the time of the request, and since subsequent changes in eligibility may not yet be available; verification of eligibility is not a guarantee of coverage or payment. See your Agreement for additional details.

Member Rights and Responsibilities
Louisiana Health Cooperative members have specific rights and responsibilities when it comes to their care. The member rights and responsibilities are outlined below.
Members have the right to:

- Have information provided in a way that works for them including information that is available in alternate languages and formats;
- Be treated with fairness, respect, and dignity;
- See Louisiana Health Cooperative providers, get Covered Services, and get their prescriptions filled in a timely manner;
• Privacy and to have their protected health information (PHI) protected;
• Information about Louisiana Health Cooperative, its network of providers, their Covered Services, and their rights and responsibilities;
• Know their treatment choices and participate in decisions about their health care;
• Use Advance Directives (such as a living will or a durable health care power of attorney);
• Make complaints about Louisiana Health Cooperative or the care provided and feel confident it will not affect the way they are treated;
• Appeal medical or administrative decisions Louisiana Health Cooperative has made by using the grievance process;
• Make recommendations about Louisiana Health Cooperative’s member rights and responsibilities policies; and
• Talk openly about care needed for their health, regardless of cost or benefit coverage, as well as the choices and risks involved. The information must be given to members in a way they understand.

Members also have certain responsibilities. These include the responsibility to:
• Become familiar with their coverage and the rules they must follow to get care as a member;
• Tell Louisiana Health Cooperative and providers if they have any additional health insurance coverage or prescription drug coverage;
• Tell their PCP and other health care providers that they are enrolled in Louisiana Health Cooperative;
• Give their PCP and other providers complete and accurate information to care for them, and to follow the treatment plans and instructions that they and their providers agree upon;
• Understand their health problems and help set treatment goals that they and their doctor agree to;
• Ask their PCP and other providers questions about treatment if they do not understand;
• Make sure their doctors know all of the drugs they are taking, including over-the-counter drugs, vitamins, and supplements;
• Act in a way that supports the care given to other patients and helps the smooth running of their doctor’s office, hospitals, and other offices;
• Pay their plan premiums and any co-payments or coinsurance they owe for the Covered Services they get. Members must also meet their other financial responsibilities
• Inform Louisiana Health Cooperative if they move; and
• Inform Louisiana Health Cooperative of any questions, concerns, problems or suggestions by calling our Member Service Department.

**Changing Primary Care Providers**
Members may change their PCP selection at any time by calling Louisiana Health Cooperative’s Member Service Department.
Women’s Health Specialists
PCPs may also provide routine and preventive health care services that are specific to female members. If a female member selects a PCP who does not provide these services, she has the right to direct in-network access to a women’s health specialist for Covered Services related to this type of routine and preventive care.

Hearing-Impaired, Interpreter and Sign Language Services
Hearing-impaired, interpreter and sign language services are available to Louisiana Health Cooperative members through Member Service. PCPs should coordinate these services for members and contact Member Service if assistance is needed. Please refer to www.myLAHC.org for the Provider Services telephone numbers.

Section 3: Quality Improvement
Overview
Louisiana Health Cooperative’s Quality Improvement Program (QI Program) is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral health care and services. Strategies are identified and activities implemented in response to findings. The QI Program addresses the quality of clinical care and non-clinical aspects of service and focuses on key areas may include, but are not limited to:

- Quantitative and qualitative improvement in member outcomes;
- Coordination and continuity of care with seamless transitions across health care settings/services;
- Cultural competency;
- Quality of care/service;
- Preventative health;
- Service utilization;
- Complaints/grievances;
- Network adequacy;
- Appropriate service utilization;
- Disease and Case Management;
- Member and provider satisfaction;
- Components of operational service; and
- Regulatory/federal/state/accreditation requirements.

The QI Program activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, Healthcare Effectiveness Data and Information Set (HEDIS®) measures, and/or medical record audits. The organization’s Board of Directors has delegated authority to the Quality Improvement Committee to approve specific QI activities (including monitoring and evaluating outcomes, overall effectiveness of the QI Program, and initiating corrective action plans when appropriate) when the results are less than desired or when areas needing improvement are identified.
Information regarding the QI Program, available upon request, includes a description of the QI Program and a report on Louisiana Health Cooperative’s progress in meeting goals. Louisiana Health Cooperative evaluates the effectiveness of the QI Program on an annual basis. An annual report is published which reviews completed and continuing QI activities. This report addresses the quality of clinical care and service, trends measures to assess performance in quality of clinical care and quality of service, identifies any corrective actions implemented or corrective actions which are recommended or in progress, and identifies any modifications to the QI Program. It is available as a written document and is posted to the Provider Portal annually.

Quality Improvement Activities
The following are Quality Improvement activities performed by Louisiana Health Cooperative on an ongoing basis:

- Preventive health maintenance;
- Development and review of Clinical Practice Guidelines;
- Disease Management initiatives;
- HEDIS® studies;
- State QI projects;
- Referrals for quality issues;
- Provider-specific issues identified through tracking and trending of complaints or referrals;
- Medical record content reviews – please review the Medical Records section below for specific documentation standards and requirements; and
- Chronic care improvement programs.

Provider Participation in the Quality Improvement Program
Providers are contractually required to comply with quality improvement activities, such as HEDIS® activities and medical records reviews.

Providers are also invited to volunteer for participation in the QI Program. Avenues for voluntary participation include committee representation, quality/performance improvement projects, and feedback/input via satisfaction surveys, grievances, and calls to Member Service. Provider participation in quality activities helps facilitate integration of service delivery and benefit management.

Member Satisfaction
On an annual basis, Louisiana Health Cooperative conducts a member satisfaction survey of a representative sample of members. Satisfaction with services, quality, and access is evaluated. The results are compared to performance goals, and improvement action plans are developed to address any areas not meeting the standard.

Patient Safety to include Quality of Care and Quality of Service
Programs promoting patient safety are a public expectation, a legal and professional standard, and an effective risk-management tool. As an integral component of health care delivery by all providers, Louisiana Health Cooperative supports identification and implementation of a
complete range of patient safety activities. These activities include medical record legibility and documentation standards, communication and coordination of care across the health care network, medication allergy awareness/documentation, drug interactions, utilization of evidence-based clinical guidelines to reduce practice variations, tracking and trending adverse events/quality of care issues/quality of service issues and grievances related to safety. Patient safety is also addressed through adherence to clinical guidelines that target preventable conditions. Preventive services include:

- Regular checkups;
- Immunizations; and
- Diagnostic tests as defined by the Affordable Care Act as Essential Health Benefits (EHB).

Preventive guidelines address prevention and/or early detection interventions, and the recommended frequency and conditions under which interventions are required. Prevention activities are based on reasonable scientific evidence, best practices, and the member’s needs. Prevention activities are reviewed and approved by Louisiana Health Cooperative’s professional committees with input from participating providers and Louisiana Health Cooperative’s Quality Improvement Committee. Activities include distribution of information, encouragement to utilize screening tools and ongoing monitoring and measuring of outcomes. While Louisiana Health Cooperative implements activities to identify interventions, the support and activities of families, friends, providers and the community have a significant impact on prevention.

**Clinical Practice Guidelines**

Louisiana Health Cooperative adopts validated evidence-based *Clinical Practice Guidelines (CPGs)* and utilizes the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other provider may supersede CPGs, the guidelines provide clinical staff and providers with information about medical standards of care to assist in applying evidence from research in the care of both individual members and populations. The CPGs are based on peer-reviewed medical evidence and are relevant to the population served. Approval of the CPGs occurs through the Quality Improvement Committee. *Clinical Practice Guidelines*, to include preventative health guidelines, are on Louisiana Health Cooperative’s website at [www.myLAHC.org](http://www.myLAHC.org)

**Healthcare Effectiveness Data and Information Set**

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90% of America’s managed care organizations to measure performance on important dimensions of care and service. The 2013 tool comprises 80 measures across five domains of care, including:

- Effectiveness of Care;
- Access and Availability of Care;
- Experience of Care;
- Health Plan Descriptive Information; and
- Utilization and Relative Resource Use.
HEDIS® is a mandatory process that occurs annually. It is an opportunity for Louisiana Health Cooperative and providers to demonstrate the quality and consistency of care that is available to members. Medical records and claims data are reviewed to capture required data. Compliance with HEDIS® standards is reported on an annual basis with results available to providers upon request. Through compliance with HEDIS® standards, members benefit from the quality and effectiveness of care received and providers benefit by delivering industry-recognized standards of care to achieve optimal outcomes.

Section 4: Utilization Management, Case Management and Disease Management

Utilization Management

Overview
The Utilization Management (UM) Program defines and describes Louisiana Health Cooperative’s multidisciplinary, comprehensive approach and process to manage resource allocation. The UM Program describes the use of the Clinical Care Integration Department’s review guidelines, Louisiana Health Cooperative’s adverse determination process, the assessment of new technology, and delegation oversight.

The UM program includes components of prior authorization, concurrent and retrospective review activities. Each component is designed to provide for the evaluation of health care and services based on member coverage, appropriateness of such care and services, and to determine the extent of coverage and payment to providers of care.

Louisiana Health Cooperative does not reward its associates, practitioners, physicians, or other individuals or entities performing utilization management activities for rendering denial of coverage, services or care determinations. Louisiana Health Cooperative does not provide for financial incentives, encourage or promote under-utilization.

Medical Necessity
Medically necessary services are defined as services that include medical or allied care, goods or services furnished or ordered to:

- Be necessary to protect life, prevent significant illness or significant disability or to alleviate severe pain;
- Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the member’s needs;
- Be consistent with the generally accepted professional medical standards and not be experimental or investigational;
• Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
• Be furnished in a manner not primarily intended for the convenience of the member, the member’s caretaker, or the provider.

Medically necessary or medical necessity for those services furnished in a hospital on an inpatient basis are ones that cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended, or approved medical or allied health goods or services does not, in itself, make such goods or services medically necessary, a medical necessity, or a Covered Service/benefit.

Prior Authorization
Prior authorization allows for efficient use of Covered Services and ensures that members receive the most appropriate level of care in the most appropriate setting. Prior authorization may be obtained by the member’s PCP, treating specialist, or facility. Louisiana Health Cooperative provides a process in order to make a determination of medical necessity and benefits coverage for inpatient and outpatient services prior to services being rendered. Prior authorization requirements apply to pre-service decisions.

Providers may submit request for authorization by downloading a medical necessity request form from the Providers page on www.myLAHC.org. Submit requests for authorization by:
• Faxing a properly completed Medical Necessity Request; or
• Contacting Louisiana Health Cooperative via phone for inpatient notifications and urgent outpatient services.

It is necessary to include the following information in the request for services:
• Member name and identification number;
• The requesting provider’s demographics;
• Diagnosis code(s) and place of service;
• Services being requested and Physician’s Current Procedural Terminology, 4th Edition (CPT-4) code(s);
• The recommended provider’s demographics to provide the service; and
• Medical history and any pertinent medical information related to the request, including current plan of treatment, progress notes as to the necessity, effectiveness, and goals.

For the appropriate contact information, refer to the Quick Reference Guide on Louisiana Health Cooperative’s website at www.myLAHC.org

Notification
Notifications are communications to Louisiana Health Cooperative with information related to a service rendered to a member or a member’s admission to a facility. Notification is required for a member’s admission to a hospital. This enables Louisiana Health Cooperative to log the hospital admission and follow-up with the facility on the following business day to receive clinical information. Notification can be submitted by fax, phone, or via the secure, online portal at
www.mylahc.org/providers.

**Concurrent Review**
Louisiana Health Cooperative ensures the oversight and evaluation of members when admitted to hospitals, rehabilitation centers, and skilled nursing facilities (SNF). This oversight includes reviewing continued inpatient stays to ensure appropriate utilization of health care resources and to promote quality outcomes for members.

Louisiana Health Cooperative provides oversight for members receiving acute care services in facilities mentioned above to determine the initial/ongoing medical necessity, appropriate level of care, appropriate length of stay, and to facilitate a timely discharge.

The concurrent review process is conducted based on the member’s medical condition.

Concurrent review decisions are made utilizing the following criteria:
- InterQual Severity of Illness/Intensive of Service criteria;
- Clinical Coverage Guidelines;

These review criteria are utilized as a guideline. Decisions will take into account the member’s medical condition and co-morbidities. The review process is performed under the direction of the Louisiana Health Cooperative Medical Director.

Frequency of onsite and/or telephonic review will be based on the clinical condition of the member. The frequency of the reviews for extension of initial determinations is based on the severity/complexity of the patient's condition, necessary treatment, and discharge planning activity including possible placement in a different level of care.

The treating provider and the facility utilization review staff will provide review information that is collected telephonically or via fax.

Clinical information is requested to support the appropriateness of the admission, continued length of stay, level of care, treatment, and discharge plans.

When a hospital determines that a member no longer needs inpatient care, but is unable to obtain the agreement of the physician, the hospital may request a Independent Review Organization (IROIRO) review. Prior to requesting a IROIRO review, the hospital should consult with Louisiana Health Cooperative.

**Discharge Planning**
Louisiana Health Cooperative identifies and provides the appropriate level of care as well as medically necessary support services for members upon discharge from an inpatient setting. Discharge planning begins upon notification of the member’s inpatient status to facilitate continuity of care, post-hospitalization services, referrals to a SNF or rehabilitation facility, evaluating for a lower level of care, and maximizing services in a cost-effective manner. As part of the UM process, Louisiana Health Cooperative will provide for continuity of care when transitioning members from one level of care to another. The discharge plan will include a comprehensive evaluation of the member’s health needs and identification of the services and supplies required to facilitate appropriate care following discharge from an institutional setting.
This will be based on the information received from the institution and/or provider caring for the member.

Some of the services involved in the discharge plan include, but are not limited to:
- Durable Medical Equipment (DME);
  Transfers to an appropriate level of care, such as an inpatient nursing rehabilitation (INR) facility, long term acute care facility (LTAC) or SNF; Home Health Care;
- Medications; and
- Physical, Occupational, or Speech Therapy (PT, OT, ST).

**Retrospective Review**
A retrospective review is any review of care or services that have already been provided. Louisiana Health Cooperative will review post-service requests for authorization of inpatient admissions or outpatient services. The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions, and taking into account the member’s needs at the time of service. Louisiana Health Cooperative will also identify quality issues, utilization issues, and the rationale behind failure to follow Louisiana Health Cooperative’s prior authorization/pre-certification guidelines.

Louisiana Health Cooperative will give a written notification to the requesting provider and member within 30 calendar days of receipt of a request for a UM determination. If Louisiana Health Cooperative is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, for up to 15 calendar days of the post-service request.

**Referrals**
Referrals are requests by a PCP for a member to be evaluated and/or treated by a participating specialty provider. LAHC allows members direct access to any Participating Provider for an office visit without a referral.

**Criteria for Utilization Management Determinations**
The UM Department utilizes review criteria that are nationally recognized and based on sound scientific medical evidence. Providers with an unrestricted license, professional knowledge and/or clinical expertise in the area actively participate in the discussion, adoption and application of all utilization decision-making criteria on an annual basis.

The UM program uses numerous sources of information including, but not limited to, the following list when making coverage determinations:
- InterQual;
- Medical necessity;
- Member benefits;
- Local and federal statutes and laws.

The nurse reviewer and/or Medical Director apply medical necessity criteria in the context of the member’s individual circumstance and capacity of the local provider delivery system. When the above criteria do not address the individual member’s needs or unique circumstance; the medical director will use clinical judgment in making the determination.

Members and providers may request a copy of the criteria utilized for a specific determination of
medical necessity by contacting Customer Service.

The medical review criteria stated below are updated and approved at least annually by the Medical Director, Clinical Guidelines Committee, and Quality Improvement Committee. Appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria or scripts being reviewed have an opportunity to give advice or comment on development or adoption of UM criteria and on instructions for applying the criteria.

Louisiana Health Cooperative is responsible for:
- Requiring consistent application of review criteria for authorization decisions;
- Consulting with the requesting provider when appropriate;
  Collecting patient specific clinical information from physician, providers or clinical professionals at the hospital and/or facility to assess continued medical necessity of services.

When applying criteria to members with more complicated conditions, Louisiana Health Cooperative will consider the following factors:
- Age;
- Co-morbidities;
- Complications;
- Progress of treatment;
- Psychological situation; and
- Home environment, when applicable.

Louisiana Health Cooperative will also consider characteristics of the local delivery system available for specific members, such as:
- Availability of SNFs, sub-acute care facilities, or home care in Louisiana Health Cooperative’s service area to support the member after hospital discharge;
- Coverage of benefits for SNFs, sub-acute care facilities, or home care when needed; and
  Local hospitals’ ability to provide all recommended services within the estimated length

When Louisiana Health Cooperative’s standard UM guidelines and criteria do not apply due to individual patient (member) factors and the available resources of the local delivery system, the Health Services staff (Review Nurse, Case Manager) will conduct individual case conferences to determine the most appropriate alternative service for that member. The Medical Director may also utilize her or his clinical judgment in completing the service authorization request.

**Utilization Management Decisions**
For all organization determinations, providers may contact Louisiana Health Cooperative by mail, phone, fax, or via our website.

Louisiana Health Cooperative requires prior authorization and/or pre-certification for:
- Bone growth stimulator
- Cardiac Rehabilitation
- CT Scans
- Day Rehabilitation Programs
- Dialysis
• Durable Medical Equipment (Greater than $300)
• Electric and Custom Wheelchairs
• Home Health Care
• Hospice
• Hyperbarics
• Implantable Medical Devices over $2,000 such as Implantable Defibrillator and Insulin Pumps
• Infusion Therapy (Exception: Infusion Therapy performed in a Physician’s office does not require prior Authorization. The drug to be infused may require prior Authorization).
• Low Protein Food Products
• MRI/MRA
• Non-Emergency Air Ambulance
• Nuclear Cardiology
• Oral Surgery (not required when performed in a Physician’s office)
• Organ Transplant Evaluation
• Orthotic Devices
• Outpatient surgical procedures not performed in a Physician’s office
• Outpatient non-surgical procedures (Exceptions: X-rays, lab work, physical therapy, occupational therapy, speech therapy and chiropractic services do not require prior Authorization. Non-surgical procedures performed in a Physician’s office do not require a prior Authorization).
• Outpatient Pain rehabilitation or pain control programs
• PET/SPECT Scans
• Private Duty Nursing
• Prosthetic Appliances
• Sleep Studies
• Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknife procedures
• Vacuum Assisted Wound Closure Therapy

For initial and continuation of services, Louisiana Health Cooperative has appropriate mechanisms to ensure consistent application of review criteria for authorization reviews, which include:
• Medical Necessity – approved medical review criteria will be referenced and applied;
• Inter-rater reliability – a process that evaluates the consistency of decisions made by licensed staff when making authorization decisions and ensures the consistent application of medical review criteria; and
• Consultation with the requesting provider when appropriate.

Non-urgent Pre-service Decision– An organization determination will be made as expeditiously as the member’s health condition requires, but no later than 15 calendar days after Louisiana Health Cooperative receives the request for service.

An extension may be granted for 15 additional calendar days if the member requests an extension, or if Louisiana Health Cooperative justifies a need for additional information and documents how the delay is in the interest of the member.
**Urgent Pre-Service Decision** – A member or any provider may request that Louisiana Health Cooperative expedite an organization determination when the member or his or her provider believes that waiting for a decision under the standard timeframe could place the member’s life, health, or ability to regain maximum function in serious jeopardy. The request will be made as expeditiously as the member’s health condition requires, but no later than 72 hours after receiving the member’s or provider’s request. An extension may be granted for 48 hours if the member requests an extension, or if Louisiana Health Cooperative justifies a need for additional information and documents how the delay is in the interest of the member.

Louisiana Health Cooperative’s organization determination system provides authorization numbers, effective dates for the authorization, and specifies the services being authorized. The requesting provider will be notified verbally via telephone or fax of the authorization.

In the event of an adverse determination, Louisiana Health Cooperative will notify the member and the member’s representative (if appropriate) in writing and provide written notice to the provider. Written notification to providers will include the Utilization Management Department’s contact information to allow providers the opportunity to discuss the adverse determination decision. The provider may request a copy of the criteria used for a specific determination of medical necessity by contacting the Health Services’ Utilization Management Department. The member may request a copy of the criteria used for a specific determination of medical necessity by contacting Customer Service.

**Urgent Concurrent Review**- A concurrent review is any review or an extension of a previously approved, ongoing course of treatment, over a period of time or number of treatments. Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care. LAHC makes decisions and provides notification within 24 hours of receipt of the request.

**Post-Service Decision**- A post-service decision is any review for care or services that have already been received (e.g., retrospective review). A request for coverage of care that was provided by an out-of-network practitioner and for which the required prior authorization was not obtained is a post service decision. Although the organization requires prior authorization of out-of-network care, post-service decisions include any requests for coverage of care or service that a member has already received. LAHC makes decisions and provides notification within 30 calendar days of receipt of the request.

**Reconsideration Requests**
Louisiana Health Cooperative provides an initial oral notification of a denial decision to members and practitioners for urgent pre-service and urgent current denials:

- Within 72 hours of an urgent pre-service request;
- Within 24 hours of an urgent concurrent request.

An electronic or written notification is given no later than 3 calendar days after the oral notification.

**Emergency Services**
Emergency Services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
• Needed to evaluate or stabilize an emergency medical condition.

It is Louisiana Health Cooperative’s policy that emergency services are covered:
• Regardless of whether services are obtained within or outside the network of providers available;
• Regardless of whether there is prior authorization for the services. In addition:
• No materials furnished to members (including wallet card instructions) may contain instructions to seek prior authorization for emergency services, and members must be informed of their right to call 911; and
• No materials furnished to providers, including contracts, may contain instructions to providers to seek prior authorization before the member has been stabilized;
• In accordance with a prudent layperson’s definition of “emergency medical condition” regardless of the final medical diagnosis; and
• Whenever a Louisiana Health Cooperative provider or other Louisiana Health Cooperative representative instructs a member to seek emergency services within or outside the member’s Louisiana Health Cooperative plan coverage.

Louisiana Health Cooperative is not responsible for the care provided for an unrelated non-emergency problem during treatment for an emergency situation. For example, Louisiana Health Cooperative is not responsible for any costs, such as a biopsy associated with treatment of skin lesions performed by the attending provider who is treating a fracture.

Transition of Care
If a new member has an existing relationship with a provider who is not part of Louisiana Health Cooperative’s provider network, Louisiana Health Cooperative will permit the member to continue an ongoing course of treatment by the non-participating provider during a transitional period.

Louisiana Health Cooperative will honor any written documentation of prior authorization of ongoing Covered Services for a period of 30 calendar days after the effective date of enrollment.

For all members, written documentation of prior authorization of ongoing services includes the following, provided that the services were prearranged prior to enrollment with Louisiana Health Cooperative:
• Prior existing orders;
• Provider appointments (e.g., dental appointments, surgeries, etc.); and
• Prescriptions (including prescriptions at non-participating pharmacies).

Louisiana Health Cooperative cannot delay service authorization if written documentation is not available in a timely manner. Contact the Claims Department for claims payment or claims resolution issues and your Provider Relations representative for rate negotiations.

Members who are inpatient at the time of disenrollment from Louisiana Health Cooperative will be covered by Louisiana Health Cooperative throughout the acute inpatient stay, however, Louisiana Health Cooperative will not be responsible for any discharge needs the member may have.
Louisiana Health Cooperative will take immediate action to address any identified urgent medical needs.

**Continued Care with a Terminated Provider**
When a provider terminates or is terminated without cause, Louisiana Health Cooperative will allow members in active treatment to continue either through the completion of their condition (up to 90 calendar days) or until the member selects a new provider.

Louisiana Health Cooperative will inform the provider that care provided after termination shall continue under the same terms, conditions and payment arrangements as they existed in the terminated contract.

If an obstetrical provider terminates without cause and requests an approval for treatment for a pregnant member who is in treatment, the member will be allowed to, when medically necessary, continue care according to the specific state regulations. If a provider is terminated for cause, Louisiana Health Cooperative will direct the member immediately to another participating provider for continued services and treatment.

**Continuity of Care**
Louisiana Health Cooperative maintains and monitors a panel of PCPs from which the member may select a personal PCP. All members may select and/or change their PCP to another participating Louisiana Health Cooperative PCP without interference. Louisiana Health Cooperative will also:

- Provide or arrange for necessary specialist care and in particular, give female members the option of direct access to a women’s health specialist within the network for women’s routine and preventive health care services. Louisiana Health Cooperative will arrange for specialty care outside of Louisiana Health Cooperative’s provider network when network providers are unavailable or inadequate to meet a member’s medical needs;
- Ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Louisiana Health Cooperative utilizes the provision of translator services and interpreter services;
- Establish and maintain written standards, including coverage rules, practice guidelines, payment policies, and utilization management that allow for individual medical necessity determinations;
- Provide coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services; and
- Have in effect procedures that:
  - Establish and implement a treatment plan that is appropriate;
  - Include an adequate number of direct access visits to specialists;
  - Are time-specific and updated periodically;
  - Facilitate coordination among providers; and
  - Considers the member’s input.

**Second Opinion**
Members have the right to a second surgical/medical opinion in any instance when
the member disagrees with his or her provider’s opinion of the reasonableness or necessity of surgical procedures or is subject to a serious injury or illness. The second surgical/medical opinion, if requested, is to be provided by a provider chosen by the member who may select:

- A provider that is participating with Louisiana Health Cooperative; or
- A non-participating provider located in the same geographical service area of Louisiana Health Cooperative, if a participating provider is not available.

If Louisiana Health Cooperative’s network is unable to provide necessary services to a particular member, Louisiana Health Cooperative will adequately and timely cover these services out-of-network for the member for as long as Louisiana Health Cooperative is unable to provide them. Louisiana Health Cooperative will be financially responsible for a second surgical/medical opinion.

Members must inform their PCP of their desire for a second surgical/medical opinion. If a participating Louisiana Health Cooperative provider is selected, the PCP will issue a referral to the member for the visit. If a non-participating provider is required, the PCP will contact Louisiana Health Cooperative for authorization.

Any tests that are deemed necessary as a result of the second surgical/medical opinion will be conducted by participating Louisiana Health Cooperative providers. The PCP will review the second surgical/medical opinion and develop a treatment plan for the member. If the PCP disagrees with the second surgical/medical opinion request for services, the PCP must still submit the request for services to Louisiana Health Cooperative for an organization determination on the recommendation.

The member may file an appeal if Louisiana Health Cooperative denies the second surgical/medical opinion provider’s request for services. The member may file a grievance if the member wishes to follow the recommendation of the second opinion provider and the PCP does not forward the request for services to Louisiana Health Cooperative.

**Notification of Hospital Discharge Appeal Rights**

Prior to discharging a member or lowering the level of care within a hospital setting, Louisiana Health Cooperative will secure concurrence from the provider responsible for the member’s inpatient care.

Louisiana Health Cooperative will ensure members receive a valid written notification of termination of inpatient services from the facility. Hospitals must issue the *Important Message* within two calendar days of admission, obtain signature of the patient or the signature of their authorized representative, and provide a signed follow-up copy to the patient as far in advance of discharge as possible, but not more than two calendar days before discharge. This letter will include the process to request an immediate review with the appropriate IRO.

Members who desire an immediate review must submit a request to the IRO, in writing or by telephone, by midnight (12 a.m.) of the day of discharge. The request must be submitted before the member leaves the hospital.

If the member fails to make a timely request to the IRO she or he may request an expedited reconsideration by Louisiana Health Cooperative.
Upon notification by the IRO that a member has requested an immediate review, Louisiana Health Cooperative will contact the facility, request all relevant medical records, a copy of the executed IM, and evaluate for validity. If after review, Louisiana Health Cooperative concurs that the discharge is warranted, Louisiana Health Cooperative will issue a *Detailed Notice of Discharge* providing a detailed reason why services are either no longer reasonable, necessary or are no longer covered.

Coverage of inpatient services continues until the date and time designated on the *Detailed Notice of Discharge*, unless the member requests an immediate IRO review. Liability for further inpatient hospital services depends on the IRO decision.

If the IRO determines that the member did not receive valid notice, coverage of inpatient services by Louisiana Health Cooperative continues until at least two calendar days after valid notice has been received. Continuation of coverage is not required if the IRO determines that the coverage could pose a threat to the member’s health or safety.

The burden of proof lies with Louisiana Health Cooperative to demonstrate that discharge is the correct decision, based on medical necessity. To meet this burden, Louisiana Health Cooperative must supply any and all information that the IRO requires to sustain Louisiana Health Cooperative’s decision.

Louisiana Health Cooperative is financially responsible for coverage of services, regardless of whether it has delegated responsibility for authorizing coverage or termination decisions to its providers.

If the IRO reverses Louisiana Health Cooperative’s termination decision, Louisiana Health Cooperative must provide the member with a new notice when the hospital or Louisiana Health Cooperative once again determines that the member no longer requires acute inpatient hospital care.

**Availability of Utilization Management Staff**
Louisiana Health Cooperative’s Clinical Care Integration Department provides medical and support staff resources, including a Medical Director, to process requests and provide information for the routine or urgent authorization/pre-certification of services, utilization management functions, provider questions, comments or inquiries. We are available 24 hours per day, seven days per week, including holidays.

For more information on contacting the Clinical Care Integration Department via Provider Services, refer to the *Quick Reference Guide* on Louisiana Health Cooperative’s website at [www.myLAHC.org](http://www.myLAHC.org)

**Case Management Program**
Overview
Louisiana Health Cooperative offers comprehensive case management services to facilitate patient assessment, planning and advocacy to improve health outcomes for patients. Louisiana Health Cooperative trusts providers will help coordinate the placement and cost-effective treatment of patients who are eligible for Louisiana Health Cooperative’s Case Management Programs.

Louisiana Health Cooperative’s Case Management teams are led by specially trained Registered Nurse and Licensed Clinical Social Worker Case Managers who assess the member’s risk factors, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the care plan.

The Case Managers work collaboratively with PCPs and specialists to coordinate care for the member and expedite access to care and needed services.

Louisiana Health Cooperative’s Case Management teams also serve in a support capacity to the PCP and assist in actively linking the member to providers, medical services, residential, social and other support services, as needed. Providers may request case management services for any member.

The Case Management process begins with member identification, and follows the member until discharge from the Program. Members may be identified for Case Management in various ways, including:

- a referral from a member’s PCP;
- self-referral;
- referral from a family member;
- after completing a Health Risk Assessment; and
- data mining for members with high utilization.

Louisiana Health Cooperative’s philosophy is that the Case Management Program is an integral management tool in providing a continuum of care for members. Key elements of the Case Management process include:

- **Clinical Assessment and Evaluation** – a comprehensive assessment of the member is completed to determine where she or he is in the health continuum. This assessment gauges the member’s support systems and resources and seeks to align them with appropriate clinical needs;
- **Care Planning** – collaboration with the member and/or caregiver as well as the PCP to identify the best ways to fill any identified gaps or barriers to improve access and adherence to the provider’s plan of care;
- **Service Facilitation and Coordination** – working with community resources to facilitate member adherence with the plan of care. Activities may be as simple as reviewing the plan with the member and/or caregiver or as complex as arranging services, transportation and follow-up; and
- **Member Advocacy** – advocating on behalf of the member within the complex labyrinth of the health care system. Case Managers assist members with seeking the services to
optimize their health. Case Management emphasizes continuity of care for members through the coordination of care among physicians and other providers.

Members commonly identified for Louisiana Health Cooperative’s Case Management Program may include:

- **Catastrophic Injuries** – such as head injury, near drowning, burns;
- **Multiple Chronic Conditions** – multiple co-morbidities such as diabetes, chronic obstructive pulmonary disease (COPD), and hypertension, or multiple barriers to quality health care (i.e., Acquired Immune Deficiency Syndrome (AIDS));
- **Transplantation** – organ failure, donor matching, post-transplant follow-up; and
- **Complex Discharge Needs** - members discharged home from acute inpatient or SNF with multiple service and coordination needs (i.e., DME, PT/OT, home health); complicated, non-healing wounds, advanced illness, etc.

Case Managers work closely with the provider regarding when to discharge the member from the Case Management Program. Reasons for discharge from the Case Management Program may include:

- The member is meeting primary care plan goals;
- The member has declined additional case management services;
- The member has disenrolled from Louisiana Health Cooperative; and/or
- The member is unable to be contacted by Louisiana Health Cooperative.

**Provider Access to Case Management**
Refer to *Access to Case and Disease Management Programs* in the *Disease Management* section below.

**Disease Management Program**

**Overview**
Disease Management (DM) is a population-based strategy that involves consistent care across the continuum for members with certain disease states. Elements of the program include educating the member about the particular disease and self-management techniques, monitoring the member for adherence to the treatment plan and consistently using validated, industry-recognized evidence-based *Clinical Practice Guidelines* by the treatment team and the Disease Manager.

The DM Program includes the following conditions:

- Cardiac (including Congestive Heart Failure); and
- Diabetes.

**Candidates for Disease Management**
Louisiana Health Cooperative encourages referrals from providers, members, hospital discharge planners and others in the health care community.

Interventions for members identified vary depending on their level of need and stratification level. Interventions are based on industry-recognized *Clinical Practice Guidelines*. Members
identified at the highest stratification levels receive a comprehensive assessment by a DM nurse, disease-specific educational materials, identification of a care plan and goals and follow-up assessments to monitor adherence to the plan and attain goals.

Disease-specific *Clinical Practice Guidelines* adopted by Louisiana Health Cooperative may be on Louisiana Health Cooperative’s website at [www.myLAHC.org](http://www.myLAHC.org).

**Section 5: Claims**

**Overview**
The focus of the Claims Department is to process claims in a timely manner. Louisiana Health Cooperative has established toll-free telephone numbers for providers to access a representative. For more information on claims submission, refer to the *Quick Reference Guides* or Louisiana Health Cooperative’s website at [www.myLAHC.org](http://www.myLAHC.org).

**Timely Claims Submission**
Unless otherwise stated in your Agreement, you must submit clean claims (initial, corrected and voided) to Louisiana Health Cooperative within 180 calendar days from the date of discharge for inpatient services or the date of service for all other services. The start date for determining the timely filing period is the “from” date reported on a CMS-1500 or 837-P for professional claims or the “through” date used on the UB-04 or 837-I for institutional claims.

Unless prohibited by federal law, Louisiana Health Cooperative may deny payment of any claim that fails to meet Louisiana Health Cooperative’s submission requirements for clean claims or failure to timely submit a clean claim to Louisiana Health Cooperative.

Please note that claims filed by providers who are not part of the network must be filed no later than 12 months, or one calendar year, after the date the services were furnished.

The following items can be accepted as proof that a claim was submitted timely:
- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by Louisiana Health Cooperative; and
- A provider’s electronic submission sheet that contains all the following identifiers:
  - patient name;
  - provider name;
  - date of service to match Explanation of Benefits (EOB)/claim(s) in question;
  - prior submission bill dates; and
  - Louisiana Health Cooperative’s product name or line of business.

The following items are examples of what is not acceptable as evidence of timely submission:
- Strategic National Implementation Process (SNIP) Rejection Letter; and
• A copy of the provider’s billing screen.

**Tax ID and National Provider Identifier Requirements**
Louisiana Health Cooperative requires the payer-issued Tax Identification Number (Tax ID / TIN) and National Provider Identifier (NPI) on all claims submissions, with the exception of atypical providers. Atypical providers must pre-register with Louisiana Health Cooperative before submitting claims to avoid NPI rejections. Louisiana Health Cooperative will reject claims without the Tax ID and NPI.

**Taxonomy**
Providers are encouraged to submit claims with the correct taxonomy code consistent with provider’s specialty and services being rendered in order to increase appropriate adjudication. Louisiana Health Cooperative may reject the claim or pay it at the lower reimbursement rate if the taxonomy code is incorrect or omitted.

**Preauthorization number**
If a preauthorization number was obtained, the provider must include this number in the appropriate data field on the claim.

**Strategic National Implementation Process**
All claims and encounter transactions submitted via paper, direct data entry (DDE), or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines. If a claim is rejected for lack of compliance with Louisiana Health Cooperative’s claim and encounter submission requirements, the rejected claim should be resubmitted within timely filing limits. For more information on encounters, see the *Encounters Data* section below.

**Claims Submission Requirements**
Providers using electronic submission shall submit clean claims to Louisiana Health Cooperative or its designee, as applicable, using the HIPAA-compliant 837 electronic format or a CMS 1500/UB-04 (or their successors), as applicable. Claims shall include the provider’s NPI, tax ID and the valid taxonomy code that most accurately describes the services reported on the claim. The provider acknowledges and agrees that no reimbursement or compensation is due for a Covered Service, and no claim is complete for a Covered Service, unless performance of that Covered Service is fully and accurately documented in the member’s medical record prior to the initial submission of any claim. The provider also acknowledges and agrees that at no time shall members be responsible for any payments to the provider with the exception of member expenses or non-covered services. For more information on paper submission of claims, refer to the *Quick Reference Guide* or Louisiana Health Cooperative’s website at [www.myLAHC.org](http://www.myLAHC.org). For more information on Louisiana Health Cooperative’s Covered Services, refer to Louisiana Health Cooperative’s website at [www.myLAHC.org](http://www.myLAHC.org).

**Electronic Claims Submissions**
Louisiana Health Cooperative accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to Louisiana Health Cooperative must be in the ANSI ASC X12N format, version 5010A, or its successor.

Because most clearinghouses can exchange data with one another, providers should work with their existing clearinghouse, or the clearinghouses Louisiana Health Cooperative uses to establish EDI with Louisiana Health Cooperative. For a list of clearinghouses Louisiana Health Cooperative uses, for information on the Louisiana Health Cooperative’s unique payer identification numbers used to identify Louisiana Health Cooperative on electronic claims submissions, or to contact Louisiana Health Cooperative’s EDI team, refer to the Provider Resource Guide on Louisiana Health Cooperative’s website at www.myLAHC.org.

**HIPAA Electronic Transactions and Code Sets**

*>HIPAA Electronic Transactions and Code Sets* is a federal mandate that requires health care payers such as Louisiana Health Cooperative, as well as providers engaging in one or more of the identified transactions, to have the capability to send and receive all standard electronic transactions using the HIPAA designated content and format.

To promote consistency and efficiency for all claims and encounter submissions to Louisiana Health Cooperative, it is Louisiana Health Cooperative’s policy that these requirements apply to all paper and DDE transactions.

**Paper Claims Submissions**

Providers are encouraged to submit claims to Louisiana Health Cooperative electronically. All paper claims must be submitted on original (red ink on white paper) claim forms. Any missing, illegible, incomplete or invalid information in any field will cause the claim to be rejected or processed incorrectly. All paper claims and encounters should be submitted to:

<table>
<thead>
<tr>
<th>PHCS claims should be mailed to:</th>
<th>Verity/Other claims should be mailed to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHCS</td>
<td>GRI</td>
</tr>
<tr>
<td>P.O. Box 21823</td>
<td>P.O. Box 100043</td>
</tr>
<tr>
<td>Eagan, MN 55121</td>
<td>Duluth, GA 30096-9343</td>
</tr>
</tbody>
</table>

**Claims Processing**
Readmission
Louisiana Health Cooperative may choose to review claims if data analysis deems it appropriate. Louisiana Health Cooperative may review hospital admissions on a specific member if it appears that two or more admissions are related based on the data analysis. Based upon the claim review (including a review of medical records if requested from the provider) Louisiana Health Cooperative will make all necessary adjustments to the claim, including recovery of payments which are not supported by the medical record. Louisiana Health Cooperative may recoup overpayments from providers who do not submit the requested medical records or who do not remit the overpayment amounts identified by Louisiana Health Cooperative.

Prompt Payment
Louisiana Health Cooperative will pay clean claims in accordance with the terms of the Agreement.

Coordination of Benefits (COB)
Louisiana Health Cooperative shall coordinate payment for Covered Services in accordance with the terms of a member’s benefit plan, applicable state and federal laws. Providers shall bill primary insurers for items and services they provide to a member before they submit claims for the same items or services to Louisiana Health Cooperative. Any balance due after receipt of payment from the primary payer should be submitted to Louisiana Health Cooperative for consideration and the claim must include information verifying the payment amount received from the primary plan as well as a copy of the EOB.

Encounters Data

Overview
This section is intended to give providers necessary information to allow them to submit encounter data to Louisiana Health Cooperative.

Timely and Complete Encounters Submission
Unless otherwise stated in the Agreement, vendors and providers should submit complete and accurate encounter files to Louisiana Health Cooperative as follows:
- On a weekly basis;
- Capitated entities will submit within 10 calendar days of service date; and
- Non-capitated entities will submit within 10 calendar days of the paid date.

The above apply to both corrected claims (error correction encounters) and cap-priced encounters.

Billing the Member
Louisiana Health Cooperative reimburses only services that are medically necessary and covered through the Louisiana Health Cooperative program. Providers are not allowed to “balance bill”
for covered services if the provider’s usually and customary charge for covered services is greater than our fee schedule.

Providers may bill members for services NOT covered by Louisiana Health Cooperative or for applicable co-payments, deductibles or coinsurance as defined by the Benefit Schedule.

For more detailed information on Louisiana Health Cooperative billing requirements, please refer to the Billing Manual available on the website www.myLAHC.org.
Section 6: Credentialing

Overview
Credentialing is the process by which the appropriate Louisiana Health Cooperative peer review bodies evaluate the credentials and qualifications of practitioners including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities, and other ancillary facilities/health care delivery organizations. For purposes of Section 6: Credentialing in this Manual, all references to “practitioners” shall include providers providing health or health-related services including the following: physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities, and other ancillary facilities/health care delivery organizations.

This review includes (as applicable to practitioner type):

- Background;
- Education;
- Postgraduate training;
- Certification(s);
- Experience;
- Work history and demonstrated ability;
- Patient admitting capabilities;
- Licensure, regulatory compliance and health status which may affect a practitioner’s ability to provide health care; and
- Accreditation status, as applicable to non-individuals.

Practitioners are required to be credentialed prior to being listed as a Louisiana Health Cooperative-participating network provider of care or services to its members. The Credentialing Department, or its designee, is responsible for gathering all relevant information and documentation through a formal application process. The practitioner credentialing application must be attested to by the applicant as being correct and complete. The application captures professional credentials and asks for information regarding professional liability claims history and suspension or restriction of hospital privileges, criminal history, licensure, Drug Enforcement Administration (DEA) certification.

Please take note of the following credentialing process highlights:

- Primary source verifications are obtained in accordance with state and federal regulatory agencies, accreditation, and Louisiana Health Cooperative policy and procedure requirements, and include a query to the National Practitioner Data Bank.
- Physicians, allied health professionals, and ancillary facilities/health care delivery organizations are required to be credentialled in order to be network providers of services to Louisiana Health Cooperative members.
- Satisfactory site inspection evaluations are required to be performed in accordance with state and federal accreditation requirements.
- After the credentialing process has been completed, a timely notification of the credentialing decision is forwarded to the provider.
Credentialing may be done directly by Louisiana Health Cooperative or by an entity approved by Louisiana Health Cooperative for delegated credentialing. In the event that credentialing is delegated to an outside agency, the agency shall be required to meet Louisiana Health Cooperative’s criteria to ensure that the credentialing capabilities of the delegated entity clearly meet federal and state accreditation (as applicable) and Louisiana Health Cooperative requirements.

All participating providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a regular basis, and formal audits are conducted annually. Ongoing oversight includes regular exchanges of network information and the annual review of policies and procedures, credentialing forms, and files.

**Practitioner Rights**
Practitioner Rights are listed below and are included in the application/re-application cover letter.

**Practitioner’s Right to Be Informed of Credentialing/Re-Credentialing Application Status**
Upon receipt of a written request, Louisiana Health Cooperative will provide written information to the practitioner on the status of the credentialing/re-credentialing application, generally within 15 business days. The information provided will advise of any items pending verification, needing to be verified, any non-response in obtaining verifications, and any discrepancies in verification information received compared with the information provided by the practitioner.

**Practitioner’s Right to Review Information Submitted in Support of Credentialing/ Re-Credentialing Application**
The practitioner may review documentation submitted by him or her in support of the application/re-credentialing application, together with any discrepant information received from professional liability insurance carriers, state licensing agencies, and certification boards, subject to any Louisiana Health Cooperative restrictions. Louisiana Health Cooperative, or its designee, will review the corrected information and explanation at the time of considering the practitioner’s credentials for provider network participation or re-credentialing.

The provider may not review peer review information obtained by Louisiana Health Cooperative.

**Right to Correct Erroneous Information and Receive Notification of the Process and Timeframe**
In the event the credentials verification process reveals information submitted by the practitioner that differs from the verification information obtained by Louisiana Health Cooperative, the practitioner has the right to review the information that was submitted in support of his or her application, and has the right to correct the erroneous information. Louisiana Health Cooperative will provide written notification to the practitioner of the discrepant information.

Louisiana Health Cooperative’s written notification to the practitioner will include:
• The nature of the discrepant information;
• The process for correcting the erroneous information submitted by another source;
• The format for submitting corrections;
• The timeframe for submitting the corrections;
• The addressee in the Credentialing Department to whom corrections must be sent;
• Louisiana Health Cooperative’s documentation process for receiving the correction information from the provider; and
• Louisiana Health Cooperative’s review process.

Baseline Criteria
Baseline criteria for practitioners to qualify for provider network participation:

License to Practice – Practitioners must have a current, valid, unrestricted license to practice.

Drug Enforcement Administration Certificate – Practitioners must have a current valid DEA Certificate (as applicable to practitioner specialty), and if applicable to the state where services are performed, hold a current Controlled Dangerous Substance (CDS) or Controlled Substance Registration (CSR) certificate (applicable for M.D., D.O., D.P.M., D.D.S., D.M.D.).

Work History – Practitioners must provide a minimum of five years’ relevant work history as a health professional.

Board Certification – Physicians (M.D., D.O., D.P.M.) must maintain Board Certification in the specialty being practiced as a provider for Louisiana Health Cooperative, or must have verifiable educational/training from an accredited training program in the specialty requested.

Hospital-Admitting Privileges – Specialist practitioners shall have hospital-admitting privileges at a Louisiana Health Cooperative-participating hospital (as applicable to specialty). PCP’s may have hospital-admitting privileges or may enter into a formal agreement with another Louisiana Health Cooperative-participating provider who has admitting privileges at a Louisiana Health Cooperative-participating hospital, for the admission of members.

Liability Insurance
Louisiana Health Cooperative providers (all disciplines) are required to carry and continue to maintain professional liability insurance, unless otherwise agreed by Louisiana Health Cooperative in writing.

Providers must furnish copies of current professional liability insurance certificate to Louisiana Health Cooperative, concurrent with expiration.

Site Inspection Evaluation
Site Inspection Evaluations (SIEs) are conducted in accordance with federal, state and accreditation requirements. Focusing on quality, safety, and accessibility, performance standards and thresholds were established for:
• Office-site criteria:
  Physical accessibility;
• Physical appearance;
• Adequacy of waiting room and examination room space; and
• Medical / treatment record keeping criteria.

**SIEs are conducted for:**
• Unaccredited facilities;
• State-specific initial credentialing requirements;
• State-specific re-credentialing requirements; and
• When complaint is received relative to office site criteria.

SIEs are conducted for sites where a complaint is received relative to office site criteria listed above. SIEs may be performed for an individual complaint or quality of care concern if the severity of the issue is determined to warrant an onsite review.

**Covering Physicians**
Primary care physicians in solo practice must have a covering physician who also participates with, or is credentialed with, Louisiana Health Cooperative.

**Allied Health Professionals**
Allied Health Professionals (AHPs), both dependent and independent, are credentialed by Louisiana Health Cooperative.

Dependent AHPs include the following, and are required to provide collaborative practice information to Louisiana Health Cooperative:
• Advance Registered Nurse Practitioner (ARNP);
• Certified Nurse Midwives (CNM);
• Physician Assistant (PA); and
• Osteopathic Assistants (OA).

Independent AHPs include, but are not limited to the following:
• Licensed clinical social workers;
• Licensed mental health counselors;
• Licensed marriage and family therapists;
• Physical therapists;
• Occupational therapists;
• Audiologists; and
• Speech/language therapists/pathologists.

**Ancillary Health Care Delivery Organizations**
Ancillary and organizational applicants must complete an application and, as applicable, undergo an SIE if unaccredited.
Louisiana Health Cooperative is required to verify accreditation, licensure, regulatory status, and liability insurance coverage, prior to accepting the applicant as a Louisiana Health Cooperative participating provider.

Re-Credentialing
In accordance with regulatory, accreditation, and Louisiana Health Cooperative policy and procedure, re-credentialing is required at least once every three years.

Updated Documentation
In accordance with the Agreement, providers should furnish copies of current professional or general liability insurance, license, DEA certificate, and accreditation information (as applicable to provider type) to Louisiana Health Cooperative, prior to or concurrent with expiration.

Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials
On a regular and ongoing basis, Louisiana Health Cooperative, or its designee, contacts state licensure agencies to obtain the most current available information on sanctioned providers. This information is cross-checked against the network of Louisiana Health Cooperative providers. If a network provider is identified as being currently under sanction, appropriate action is taken in accordance with Louisiana Health Cooperative policy and procedure. If the sanction imposed is revocation of license, the provider is subject to immediate termination. Notifications of termination are given in accordance with contract and Louisiana Health Cooperative policies and procedures.

In the event a sanction imposes a reprimand or probation, written communication is made to the provider requesting a full explanation, which is then reviewed by the Credentialing/Peer Review Committee. The committee makes a determination as to whether the provider should continue participation or whether termination should be initiated.

Participating Provider Appeal through the Dispute Resolution Peer Review Process
Louisiana Health Cooperative may immediately suspend, pending investigation, the participation status of a participating provider who, in the sole opinion of Louisiana Health Cooperative’s Medical Director and Credentialing Committee, is engaged in behavior or practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of members.

Louisiana Health Cooperative has a Credentialing Committee to resolve disputes with participating practitioners regarding actions by the organization that relate to either a participating practitioner’s status within the network or any action by the organization related to a practitioner’s professional competency or conduct. In the case of a practitioner where the Committee makes an adverse determination and rejects the application, the Committee shall specify one of the two following reasons for the adverse determination:

Business or Administrative
  • Not related to the practitioner’s competence or professional conduct

Competence and Professional Conduct – Quality Related
• As it affects or may affect the health and welfare of a member
• Occurrences of this type, for physicians and non-physicians, may be reported to the National Practitioner’s Data Bank, the Department of Health Professions, Licensing and Regulation, American Medical Association, Office of Inspector General, Department of Health and Human Services and/or Department of Medical Assistance Services.

The Committee shall review all available information and notify each practitioner via certified mail of the decision to decline, suspend, reduce or terminate network privileges. In the event of an adverse event and prior to termination, a range of actions to improve performance may be provided to the practitioner (i.e., close panels to all new members, remove all members from a practitioner’s panel, restrict a practitioner to perform specific duties, require oversight of surgical procedures by another participating surgeon, periodic reviews of medical records, require continuing medical education course(s), require attendance at in-service(s), etc.). All practitioners adversely impacted shall receive instructions, in writing, on how to appeal a denied request for credentialing.

**Delegated Entities**

All participating providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a monthly/quarterly basis and formal audits are conducted annually. Please refer to Section 9: Delegated Entities of this Manual for further details.
Section 7: Reconsiderations (Appeals) and Grievances

Appeals

Provider Retrospective Appeals Overview
A provider may appeal a claim or utilization review denial on his or her own behalf by mailing or faxing Louisiana Health Cooperative a letter of appeal or an appeal form with supporting documentation such as medical records. Appeal forms are located on Louisiana Health Cooperative’s website at www.myLAHC.org

Providers have 180 calendar days from Louisiana Health Cooperative’s original utilization management review decision or claim denial to file a provider appeal. Appeals after that time will be denied for untimely filing. If the provider feels that the appeal was filed within the appropriate timeframe, the provider may submit documentation showing proof of timely filing. The only acceptable proof of timely filing is a registered postal receipt signed by a representative of Louisiana Health Cooperative, or a similar receipt from other commercial delivery services.

Upon receipt of all required documentation, Louisiana Health Cooperative has 30 calendar days to review the appeal for medical necessity and conformity to Louisiana Health Cooperative guidelines and to render a decision to reverse or affirm. Required documentation includes the member’s name and/or identification number, date of services, and reason why the provider believes the decision should be reversed. Additional required information varies based on the type of appeal being requested. For example, if the provider is requesting a medical necessity review, medical records should be submitted. If the provider is appealing a denial based on untimely filing, proof of timely filing should be submitted. If the provider is appealing the denial based on not having a prior authorization, then documentation regarding why the service was rendered without prior authorization must be submitted.

Appeals received without the necessary documentation will not be reviewed by Louisiana Health Cooperative due to lack of information. It is the responsibility of the provider to provide the requested documentation within 60 calendar days of the denial to review the appeal. Records and documents received after that time will not be reviewed and the appeal will remain closed.

Medical records and patient information shall be supplied at the request of Louisiana Health Cooperative or appropriate regulatory agencies when required for appeals. The provider is not allowed to charge Louisiana Health Cooperative or the member for copies of medical records provided for this purpose.

Provider Retrospective Appeals Decisions

Reversal of Initial Denial
If it is determined during the review that the provider has complied with Louisiana Health Cooperative protocols and that the appealed services were medically necessary, the initial denial will be reversed. The provider will be notified of this decision in writing.
The provider may file a claim for payment related to the appeal, if one has not already been submitted. After the decision to reverse the denial has been made, any claims previously denied will be adjusted for payment. Louisiana Health Cooperative will ensure that claims are processed and comply with federal and state requirements, as applicable.

**Affirmation of Initial Denial**

If it is determined during the review that the provider did not comply with Louisiana Health Cooperative protocols and/or medical necessity was not established, the initial denial will be upheld. The provider will be notified of this decision in writing. For denials based on medical necessity, the criteria used to make the decision will be provided in the letter. The provider may also request a copy of the clinical rationale used in making the appeal decision by sending a written request to the appeals address listed in the decision letter.

**Member Reconsideration Process**

**Overview**

Member reconsideration, also known as an appeal, is a formal request from a member for a review of an action taken by Louisiana Health Cooperative. Reconsideration may also be filed the member’s behalf by an authorized representative or a provider with the member’s written consent. All appeal rights described in Section 7 of this Manual that apply to members will also apply to the member’s authorized representative or a provider acting on behalf of the member with the member’s consent.

To request an appeal of a decision made by Louisiana Health Cooperative, a member may file a reconsideration request orally or in writing within 60 days from the date of the Notice of Action. If the member’s request is made orally, Louisiana Health Cooperative will mail an acknowledgment letter to the member to confirm the facts and basis of the appeal.

Examples of actions that can be appealed include, but are not limited to:

- Denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;

Louisiana Health Cooperative gives members reasonable assistance in completing forms and other procedural steps for reconsideration, including but not limited to providing interpreter services and toll-free telephone numbers with TTY/TDD and interpreter capability.

Louisiana Health Cooperative ensures that decision-makers assigned to reconsiderations were not involved in reconsiderations of previous levels of review. When deciding a reconsideration based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeal involving clinical issues, the reviewers will be health care professionals with clinical expertise in treating the member’s condition/disease or will seek advice from providers with expertise in the field of medicine related to the request.
Louisiana Health Cooperative will not retaliate against any provider acting on behalf of or in support of a member requesting reconsideration or an expedited reconsideration.

**Types of Appeals**
A member may request a standard pre-service, retrospective, or an expedited appeal.

Standard pre-service appeals are requests for services that Louisiana Health Cooperative has determined are not Covered Services, are not medically necessary, or are otherwise outside of the member’s benefit plan.

Retrospective, or post-service, appeals are typically requests for payment for care or services that the member has already received. Accordingly, a retrospective appeal would never result in the need for an expedited review. These are the only appeals that may be made by the provider on his or her own behalf.

Only pre-service appeals are eligible to be processed as an expedited appeal.

**Appeal Decision Timeframes**
Louisiana Health Cooperative will issue a decision to the member or the member’s representative within the following timeframes:

- **Standard Pre-Service Appeal:** within 30 calendar days of receipt of the request
- **Post Service Appeal:** within 60 calendar days of receipt of the request
- **Expedited Appeal:** as expeditiously as the member’s condition requires, but no later than 72 hours after the request

**Standard Pre-Service and Post Service Appeals**
A member may file a reconsideration (appeal) request either verbally or in writing within 180 calendar days of the date of the adverse determination by contacting the Customer Service Department.

After filing a written reconsideration, a member may present his or her appeal in person. To do so, the member must call Louisiana Health Cooperative to advise that the member would like to present the reconsideration in-person or via the telephone. If the member would like to present her or his appeal in-person, Louisiana Health Cooperative will arrange a time and date that works best for the member and Louisiana Health Cooperative. A member of the management team and a Louisiana Health Cooperative Medical Director will participate in the in-person appeal.

After the member presents the information, Louisiana Health Cooperative will mail the decision to the member within the timeframe specified above, based on the type of appeal.

If the member’s request for reconsideration is submitted after 180 calendar days, then good cause must be shown in order for Louisiana Health Cooperative to accept the late request. Examples of good cause include, but are not limited to:

- The member did not personally receive the adverse organization determination notice or received it late;
• The member was seriously ill, which prevented a timely appeal;

• There was a death or serious illness in the member's immediate family;
• An accident caused important records to be destroyed;
• Documentation was difficult to locate within the time limits; and/or
• The member had incorrect or incomplete information concerning the reconsideration process.

**Expedited Reconsiderations**
To request an expedited reconsideration, a member or a provider (regardless of whether the provider is affiliated with Louisiana Health Cooperative) must submit a verbal or written request directly to Louisiana Health Cooperative. A request to expedite a reconsideration of a determination will be considered in situations where applying the standard procedure could seriously jeopardize the member’s life, health or ability to regain maximum function, including cases in which Louisiana Health Cooperative makes a less than fully favorable decision to the member. In light of the short timeframe for deciding expedited reconsiderations, a provider does not need to be an authorized representative to request an expedited reconsideration on behalf of the member. However, the provider must have the member’s consent on file.

A request for payment of a service already provided to a member is not eligible to be reviewed as an expedited reconsideration.

If reconsideration is expedited, Louisiana Health Cooperative will complete the expedited reconsideration and give the member (and the provider involved, as appropriate) notice of the decision as expeditiously as the member’s health condition requires, but no later than 72 hours after receiving a valid and complete request for reconsideration.

If Louisiana Health Cooperative denies the request to expedite reconsideration, Louisiana Health Cooperative makes the expedited appeal decision and notifies members an practitioners as expeditiously as the medical condition requires but no later than 72 hours after the request. An expedited review begins when a member, the member’s representative or a practitioner acting on behalf of the member requests an expedited appeal.

• LAHC will grant an expedited review to all requests concerning admissions, continued stay or other health care services for a member that has received emergency services but has not been discharged from a facility.

**Member Reconsideration Decisions**

Reconsideration Levels
There are four levels of reconsideration available to enrollees after an adverse organization determination has been made. These levels will be followed sequentially only if the original denial continues to be upheld at each level by the reviewing entity:

1. Reconsideration of adverse organization determination by Louisiana Health Cooperative;
2. Reconsideration of adverse organization determination by the Independent Review Entity (IRE);
3. Hearing by an Administrative Law Judge (ALJ), if the appropriate threshold requirements set forth have been met;
4. Judicial Review, if the appropriate threshold requirements have been met.

**Standard Pre-Service or Retrospective Reconsideration Decisions**

If Louisiana Health Cooperative reverses its initial decision, Louisiana Health Cooperative will either issue an authorization for the pre-service request or send payment if the service has already been provided.

If Louisiana Health Cooperative affirms its initial action and/or denial (in whole or in part), it will:
- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE). The IRE has 30 days from receipt of the appeal to issue a final determination; and
- Notify the member of the decision to affirm the initial denial and that the case has been forwarded to the IRE.

Once a final determination has been made, the IRE will notify the member and Louisiana Health Cooperative. In the event the IRE agrees with Louisiana Health Cooperative, the IRE will provide the member further appeal rights.

If the IRE reverses the initial denial, the IRE will notify the member or representative in writing of the decision. Louisiana Health Cooperative will also notify the member or member’s representative in writing that the services are approved along with an authorization number.

**Expedited Reconsideration Decisions**

If Louisiana Health Cooperative reverses its initial action and/or the denial, it will notify the member verbally within 72 hours of receipt of the expedited appeal request followed with written notification of the appeal decision.

If Louisiana Health Cooperative affirms its initial action and/or denial (in whole or in part), it will:
- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE). The IRE has 72 hours from receipt of the case to issue a final determination; and
- Notify the member of the decision to affirm the initial denial and that the case has been forwarded to the IRE.

Once a final determination has been made, the IRE will notify the member and Louisiana Health Cooperative. In the event the IRE agrees with Louisiana Health Cooperative, the IRE will provide the member further appeal rights. If the IRE reverses the initial denial, the IRE notifies the member or representative in writing of the decision.
Grievances

Provider

Member Grievance Overview
The member may file a grievance. A grievance may also be filed on the member’s behalf by an authorized representative or a provider with the member’s written consent. All grievance rights described in Section 7 of this Manual that apply to members will also apply to the member’s authorized representative or a provider acting on behalf of the member with the member’s consent. Examples of issues that may result in a grievance include, but are not limited to: Provider Service including, but not limited to: Rudeness by provider or office staff; Refusal to see member (other than in the case of patient discharge from office); or Office conditions. Services provided by Louisiana Health Cooperative including, but not limited to: Hold time on telephone; Rudeness of staff; Involuntary disenrollment from Louisiana Health Cooperative; or Unfulfilled requests.

Access availability including, but not limited to: Difficulty getting an appointment; Wait time in excess of one hour; or Handicap accessibility.

A member or a member’s representative may file a standard grievance request either orally (via Customer Service or in person) or in writing within 60 calendar days of the date of the incident or when the member was made aware of the incident. Contact information for the Grievance Department Louisiana Health Cooperative’s website at www.myLAHC.org

Grievance Resolution

Standard
A member or member’s representative shall be notified of the decision as expeditiously as the case requires, based on the member’s health status, but no later than 30 calendar days after the date Louisiana Health Cooperative receives the verbal or written grievance, consistent with applicable federal law. Unless an extension is elected, Louisiana Health Cooperative will send a closure letter upon completion of the member’s grievance.

An extension of up to 14 calendar days may be requested by the member or the member’s representative. Louisiana Health Cooperative may also initiate an extension if the need for additional information can be justified and the extension is in the member’s best interest. In all cases, extensions must be well-documented. Louisiana Health Cooperative will provide the member or the member’s representative prompt written notification regarding Louisiana Health Cooperative’s intention to extend the grievance decision.
The Grievance Department will inform the member of the determination of the grievance as follows:

- All grievances submitted, either verbally or in writing, will be responded to in writing;
- and
- All grievances related to quality of care will include a description of the member’s right to file a written complaint with the Quality Improvement Organization (IRO). For any complaint submitted to a IRO, Louisiana Health Cooperative will cooperate with the IRO in resolving the complaint.

Louisiana Health Cooperative provides all members with written information about the grievance procedures/process available to them, as well as the complaint processes. Louisiana Health Cooperative also provides written information to members and/or their appointed representative(s) about the grievance procedure at initial enrollment, upon involuntary disenrollment initiated by Louisiana Health Cooperative, upon the denial of a member’s request for an expedited review of a determination or appeal, upon the member’s request, and annually thereafter. Louisiana Health Cooperative will provide written information to members and/or their appointed representatives about the IRO process at initial enrollment and annually thereafter.

The facts surrounding a complaint will determine whether the complaint is for coverage determination, organization determination or an appeal and will be routed appropriately for review and resolution.

**Expedited**
A member may request an expedited grievance if Louisiana Health Cooperative makes the decision not to expedite an organizational determination, expedite an appeal, or invoke an extension to a review. Louisiana Health Cooperative will respond to an expedited grievance within 24 hours of receipt. The grievance will be conducted to ensure that the decision to not apply an expedited review timeframe or extend a review timeframe does not jeopardize the member’s health.

Louisiana Health Cooperative will contact the member or the member’s representative via telephone with the determination and will mail the resolution letter to the member or the member’s representative within three business days after the determination is made. The resolution will also be documented in the member’s record.
Section 8: Compliance

Compliance Program - Overview
Louisiana Health Cooperative’s corporate ethics and compliance program, as may be amended from time to time, includes information regarding Louisiana Health Cooperative’s policies and procedures related to fraud, waste and abuse, and provides guidance and oversight as to the performance of work by Louisiana Health Cooperative, Louisiana Health Cooperative’s employees, contractors (including delegated entities) and business partners in an ethical and legal manner. All providers, including provider employees and provider sub-contractors and their employees, are required to comply with Louisiana Health Cooperative’s compliance program requirements. Louisiana Health Cooperative’s compliance-related training requirements include, but are not limited to, the following initiatives:

• **Quality Improvement** – Quality health is a priority for Louisiana Health Cooperative. Quality is essential for more affordable coverage. Louisiana Health Cooperative will continuously monitor, evaluate, and improve the quality and safety of care and service. Louisiana Health Cooperative’s quality improvement program is overseen by the Board of Directors (BOD). The Chief Financial Officer (CFO) develops the annual corporate budget, which includes the Quality Improvement Program’s financial needs, and submits it to the Board of Directors (BOD) for approval. The Medical Director and Vice-President of Clinical Care Integration are responsible for administration and implementation of the Quality Improvement Program. The Quality Improvement Program is evaluated annually to assess the overall effectiveness of Louisiana Health Cooperative’s quality measures. The annual evaluation will be reviewed and approved by the Quality Improvement Committee and the Board of Directors.

• **HIPAA Privacy and Security Training** - Summarizes privacy and security requirements in accordance with the federal standards established pursuant to HIPAA and subsequent amendments to HIPAA; Training includes, but is not limited to discussion on:
  - Proper uses and disclosures of PHI;
  - Member rights; and
  - Physical and technical safeguards.

• **Fraud, Waste and Abuse (FWA) Training** - must include, but not limited to:
  - Laws and regulations related to fraud, waste and abuse;
  - Obligations of the provider including provider employees and provider sub-contractors and their employees to have appropriate policies and procedures to address fraud, waste, and abuse;
  - Process for reporting suspected fraud, waste and abuse;
  - Protections for employees and subcontractors who report suspected fraud, waste and abuse; and
  - Types of fraud, waste and abuse that can occur.
Providers, including provider employees and/or provider sub-contractors, must report to Louisiana Health Cooperative any suspected fraud, waste or abuse, misconduct or criminal acts by Louisiana Health Cooperative, or any provider, including provider employees and/or provider sub-contractors, or by Louisiana Health Cooperative members. Reports may be made anonymously through the Louisiana Health Cooperative Health Plans, Inc. FWA hotline at (888) 254-5120. Details of the corporate ethics and compliance program may be found on Louisiana Health Cooperative’s website at www.myLAHC.org

**Fraud, Waste and Abuse**

Louisiana Health Cooperative is committed to the prevention, detection and reporting of health care fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements. Louisiana Health Cooperative has developed an aggressive, proactive fraud and abuse program designed to collect, analyze and evaluate data in order to identify suspected fraud and abuse. Detection tools have been developed to identify patterns of health care service use, including over-utilization, unbundling, up-coding, misuse of modifiers and other common schemes.

Federal and state regulatory agencies, law enforcement, and Louisiana Health Cooperative vigorously investigate incidents of suspected fraud and abuse. Providers are cautioned that unbundling, fragmenting, up-coding, and other activities designed to manipulate codes contained in the *International Classification of Diseases*, (ICD-9), (ICD-10), CPT, the Healthcare Common Procedure Coding System (HCPCS), and/or *Universal Billing Revenue Coding Manual* as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

In addition, providers are reminded that medical records and other documentation must be legible and support the level of care and service indicated on claims. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including but not limited to warnings, monitoring, administrative sanctions, suspension or termination as an authorized provider, loss of licensure, and/or civil and/or criminal prosecution, fines and other penalties.

To report suspected fraud and abuse, call our confidential and toll-free Louisiana Health Cooperative compliance hotline at (888) 254-5120. You may also report suspected FWA by sending an email to SIU@LAHC.com or fax to 888-244-1891. Details of the compliance program, and how to contact Louisiana Health Cooperative’s fraud hotline, may be found on Louisiana Health Cooperative’s website at www.myLAHC.org

**Confidentiality of Member Information and Release of Records**

Medical records should be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules and regulations.
All consultations or discussions involving the member or her or his case should be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the privacy and security rules and regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended. All provider practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure there is a procedure or process in place for maintaining confidentiality of members’ medical records and other PHI as defined under HIPAA; and the practice is following those procedures and/or obtaining appropriate authorization from members to release information or records where required by applicable state and federal law. Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

Every provider practice is required to provide members with information regarding their privacy practices and to the extent required by law, with their Notice of Privacy Practices (NPP). Employees who have access to member records and other confidential information are required to sign a Confidentiality Statement.

Examples of confidential information include, but are not limited to the following:

- Medical records;
- Communication between a member and a physician regarding the member’s medical care and treatment;
- All personal and/or PHI as defined under the federal HIPAA privacy regulations, and/or other state or federal laws;
- Any communication with other clinical persons involved in the member’s health, medical and mental care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number (SSN), etc.);
- Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem;
- Any communicable disease, such as AIDS or HIV testing that is protected under federal or state law.

The NPP informs the patient or member of their member rights under HIPAA and how the provider and/or Louisiana Health Cooperative may use or disclose the members’ PHI. HIPAA regulations require each covered entity to provide a NPP to each new patient or member.

**Disclosure of Information**

Periodically, members may inquire as to the operational and financial nature of their health plan. Louisiana Health Cooperative will provide that information to the member upon request. Members can request the above information verbally or in writing.

For more information on how to request this information, members may contact Customer Service using the toll-free telephone number found on the member’s ID card. Providers may contact Provider Services by referring to the *Quick Reference Guides* or Louisiana Health Cooperative’s website at [www.myLAHC.org](http://www.myLAHC.org).
Section 9: Delegated Entities

Overview
Louisiana Health Cooperative may, by written contract, delegate certain functions. These functions include, but are not limited to, contracts for administration and management services, marketing, utilization management, quality assurance, case management, disease management, claims processing, claims payment, credentialing, network management, provider claim appeals, customer service, enrollment, member functions, and sales. Louisiana Health Cooperative may delegate all or a portion of these activities to another entity (a Delegated Entity).

Louisiana Health Cooperative oversees the provision of services provided by the delegated entity and/or sub-delegate, and is accountable for the performance of all delegated functions. It is the sole responsibility of Louisiana Health Cooperative to monitor and evaluate the performance of the delegated functions to ensure compliance with regulatory requirements, contractual obligations, accreditation standards and Louisiana Health Cooperative policies and procedures.

Compliance
Louisiana Health Cooperative’s compliance responsibilities extend to delegated entities, including, without limitation:

- Compliance Plan;
- HIPAA Privacy and Security;
- Fraud, Waste and Abuse Training;
- Cultural Competency Plan; and
- Disaster Recovery and Business Continuity.

Refer to Section 8: Compliance of this Manual for additional information regarding compliance requirements.

Louisiana Health Cooperative ensures compliance through the delegation oversight process and the Delegation Oversight Committee (DOC). The DOC and its committee representatives:

- Ensure that all delegated entities are eligible for participation;
- Ensure that Louisiana Health Cooperative has written agreements with each delegated entity that specifies the responsibilities of the delegated entity and Louisiana Health Cooperative, reporting requirements, and delegated activities in a clear and understandable manner;
- Ensure that the appropriate Louisiana Health Cooperative associates have properly evaluated the entity's ability to perform the delegated activities prior to delegation;
- Provide formal, ongoing monitoring of the entity’s performance at least annually, including monitoring to ensure quality of care and quality of service is not compromised by financial incentives; and
- Impose sanctions up to and including the revocation and/or termination of delegation if the delegated entity’s performance is inadequate.
Section 10: Behavioral Health

Overview
Louisiana Health Cooperative’s UM Program is a comprehensive, systematic and ongoing effort. Review activities encompass the utilization of medical and behavioral clinical care and services including referral and triage, and inpatient and outpatient services provided by hospitals, physicians, and ancillary providers. The Behavioral Health aspects of the program encompass mental health and substance abuse issues, including chemical dependency. Behavioral Health care may be provided in either inpatient or outpatient settings. Continuity and coordination of care is evaluated, and underutilization is monitored as well as over utilization. Review activities encompass group/member agreement requirements, state/federal regulations and accreditation standards related to utilization review activities.

Please refer to the Quick Reference Guide or our website at www.myLAHC.org for information regarding how to contact the behavioral health services Unit.

Behavioral Health Program
All behavioral health services require prior authorization including services provided by non-participating providers. If a member is in need of a behavioral health provider, contact Louisiana Health Cooperative’s behavioral health services Unit as referenced in the Quick Reference Guides on Louisiana Health Cooperative’s website at www.myLAHC.org.

Coordination of Care Between Medical and Behavioral Health Providers
PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Conversely, behavioral health providers may provide physical health care services if, and when, they are licensed to do so within the scope of their practice. Behavioral providers are required to use the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) multi-axial classification when assessing the member for behavioral health services and document the DSM-IV diagnosis and assessment/outcome information in the member’s medical record.

Behavioral health providers are encouraged to submit, with the member’s or the member’s legal guardian’s consent, an initial and quarterly summary report of the member’s behavioral health status to the PCP. Communication with the PCP should occur more frequently if clinically indicated. Louisiana Health Cooperative encourages behavioral health providers to pay particular attention to communicating with PCP’s at the time of discharge from an inpatient hospitalization (Louisiana Health Cooperative recommends faxing the discharge instruction sheet or a letter summarizing the hospital stay, to the PCP). Please send this communication, with the properly signed consent, to the member’s identified PCP noting any changes in the treatment plan on the day of discharge.

We strongly encourage open communication between PCPs and behavioral health providers. If a member’s medical or behavioral condition changes, Louisiana Health Cooperative expects that both PCPs and behavioral health providers will communicate those changes to each other,
especially if there are any changes in medications that need to be discussed and coordinated between providers.

To maintain continuity of care, patient safety and member well-being, communication between behavioral health care providers and medical care providers is critical, especially for members with co-morbidities receiving pharmacological therapy. Fostering a culture of collaboration and cooperation will help sustain a seamless continuum of care between medical and behavioral health and impact member outcomes.

**Responsibilities of Behavioral Health Providers**

Louisiana Health Cooperative monitors providers against these standards to ensure members can obtain needed health services within the acceptable appointments waiting times. The provisions below are applicable only to behavioral health providers and do not replace the provisions set forth in Section 2: Provider and Member Administrative Guidelines for medical providers. Providers not in compliance with these standards will be required to implement corrective actions set forth by Louisiana Health Cooperative.

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health provider – Urgent</td>
<td>within 48 hours</td>
</tr>
<tr>
<td>Behavioral health provider – Routine office visit</td>
<td>within 10 business days</td>
</tr>
<tr>
<td>Behavioral health provider – Care for a Non-Life Threatening Emergency</td>
<td>within 6 hours</td>
</tr>
<tr>
<td>Behavioral health provider – Screening and Triage of Calls Life threatening</td>
<td>seen immediately</td>
</tr>
</tbody>
</table>

All members receiving inpatient psychiatric services must be scheduled for psychiatric outpatient follow-up and/or continuing treatment, *prior to discharge*, which includes the specific time, date, place, and name of the provider to be seen. The outpatient treatment must occur within seven days from the date of discharge.

In the event that a member misses an appointment, the behavioral health provider must contact the member within 24 hours to reschedule.

Behavioral health providers are expected to assist members in accessing emergent, urgent, and routine behavioral services as expeditiously as the member’s condition requires. Members also have access to a toll free behavioral crisis hotline that is staffed 24 hours per day. The behavioral crisis phone number is printed on the member’s card and is available on our website.

For information about Louisiana Health Cooperative’s Case Management and Disease Management programs, including how to refer a member for these services, please see Section 4: Utilization Management, Case Management and Disease Management.
Section 11: Pharmacy

Louisiana Health Cooperative’s pharmaceutical management procedures are an integral part of the pharmacy program that promotes the utilization of the most clinically appropriate agent(s) to improve the health and well-being of our members. The utilization management tools that are used to optimize the pharmacy program include:

- Formulary;
- Prior Authorization;
- Step Therapy;
- Quantity Limit; and
- Mail Service.

These processes are described in detail below. In addition, prescriber and member involvement is critical to the success of the pharmacy program. To help your patients get the most out of their pharmacy benefit, please consider the following guidelines when prescribing:

- Follow national standards of care guidelines for treating conditions, i.e., National Institutes of Health (NIH) Asthma guideline, Joint National Committee (JNC) VII Hypertension guidelines;
- Prescribe drugs listed on the formulary;
- Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class; and
- Evaluate medication profiles for appropriateness and duplication of therapy.

To contact Louisiana Health Cooperative’s Pharmacy Department, please refer to the Quick Reference Guide or for more information on Louisiana Health Cooperative’s benefits, visit our website at www.myLAHC.org.

Formulary

The formulary is a published prescribing reference and clinical guide of prescription drug products selected by the Pharmacy and Therapeutics (P&T) Committee. The formulary denotes any of the pharmacy utilization management tools that apply to a particular pharmaceutical.

The P&T Committee’s selection of drugs is based on the drug’s efficacy, safety, side effects, pharmacokinetics, clinical literature, and cost-effectiveness profile. The medications on the formulary are organized by therapeutic class, product name, strength, form and coverage details (quantity limit, prior authorization and step therapy).

The formulary is located on Louisiana Health Cooperative’s website at; www.myLAHC.org

Any changes to the list of pharmaceuticals and applicable pharmaceutical management procedures are communicated to providers via the following:

Any changes to the list of pharmaceuticals and applicable pharmaceutical management procedures are communicated to providers via the following:
• Quarterly updates in provider and member newsletters;
• Website updates; and/or
• Pharmacy and provider communication that detail any major changes to a particular therapy or therapeutic class.

Additions and Exceptions to the Formulary
To request consideration for inclusion of a drug to Louisiana Health Cooperative’s formulary, providers may write Louisiana Health Cooperative, explaining the medical justification. For contact information, refer to the Quick Reference Guide.

For more information on requesting exceptions, refer to the Coverage Determination process below.

Essential Health Benefits (EHB)-Benchmark Plan Prescription Drugs by Category and Class
Louisiana Health Cooperative offers the greater of one drug in every United States Pharmacopeia (USP) category and class or the number of drugs in each USP category and class offered by the EHB benchmark.

Generic Medications
Louisiana Health Cooperative covers both brand name drugs and generic drugs. A generic drug is approved by the (FDA) as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Step Therapy
Step Therapy programs are developed by the P&T Committee. These programs encourage the use of therapeutically equivalent, lower-cost medication alternatives (first-line therapy) before “stepping up” to less cost-effective alternatives. Step therapy programs are intended to be a safe and effective method of reducing the cost of treatment by ensuring that an adequate trial of a proven safe and cost-effective therapy is attempted before progressing to a more costly option. First-line drugs are recognized as safe, effective and economically sound treatments. The first-line drugs on our formulary have been evaluated through the use of clinical literature and are approved by our P&T Committee.

Prior Authorization
Prior authorization protocols are developed and reviewed annually by the P&T Committee. Prior authorization protocols indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s)).

Quantity Limits
Quantity limits are used to encourage that pharmaceuticals are supplied in a quantity consistent with FDA-approved dosing guidelines. Quantity limits are used to help prevent billing errors.

Injectable and Infusion Services
Self-injectable medications, specialty medications, and home infusion medications are covered as part of the outpatient pharmacy benefit. Non-formulary injectable medications and those listed on the formulary with a prior authorization will require submission of a request form for review. For more information, refer to the Obtaining a Coverage Determination Request section below.

**Over-the-Counter Medications**

Medications available to the member without a prescription are not eligible for coverage.

**Member Co-Payments**

The co-payment and/or coinsurance are based on the drug’s formulary status, including tier location, and the member’s subsidy level. Refer to the member’s Summary of Benefits for the exact co-pay/coinsurance located on Louisiana Health Cooperative’s website at [www.myLAHC.org](http://www.myLAHC.org).

**Coverage Determination Request Process**

The goal of the Coverage Determination Request program is to ensure that medication regimens that are high-risk, have a high potential for misuse or have narrow therapeutic indices are used appropriately and according to FDA-approved indications.

The Coverage Determination request process is required for:

- Drugs not listed on the formulary;
- Drugs listed on the formulary with a prior authorization;
- Duplication of therapy;
- Prescriptions that exceed the FDA daily or monthly quantity limits or prescriptions exceeding the permitted noted on the formulary;
- Most self-injectable and infusion drugs (including chemotherapy) administered in a physician’s office; and
- Drugs that have a step edit and the first line therapy is inappropriate.

**Obtaining a Coverage Determination Request**

Complete a Coverage Determination Request Form and fax it to the Pharmacy Department. The form is on Louisiana Health Cooperative’s website at [www.myLAHC.org](http://www.myLAHC.org) For the appropriate fax number, refer to the Quick Reference Guide on Louisiana Health Cooperative’s website at [www.myLAHC.org](http://www.myLAHC.org).

Louisiana Health Cooperative’s standard is to respond to Coverage Determination requests within 72 hours for routine requests and 24 hours for expedited requests from the time when Louisiana Health Cooperative receives the request.

The provider must provide medical history and/or other pertinent information when submitting a Coverage Determination Request Form for medical exception.

If the Coverage Determination Request meets the approved P&T Committee’s protocols and guidelines, the provider and/or pharmacy will be contacted with the Coverage Determination...
request approval. An approval letter is also sent to the member and a telephonic attempt is made to inform them of the approval.

If the Coverage Determination Request is not a candidate for approval based on approved P&T Committee protocols and guidelines, it is initially reviewed by a clinical pharmacist and secondly reviewed by Louisiana Health Cooperative’s Medical Director for final determination.

For those requests that are not approved, a follow-up Drug Utilization Review (DUR) Form is faxed to the provider stating why the Coverage Determination Request was not approved, including a list of the preferred drugs that are available as alternatives, if applicable. A denial letter is also sent to the member and a telephonic attempt is made to inform them of the denial.

**Medication Appeals**
To request an appeal of a Coverage Determination Request decision, contact the Pharmacy Appeals Department via fax, mail, or phone. Refer to the *Quick Reference Guide* on Louisiana Health Cooperative’s website at [www.myLAHC.org](http://www.myLAHC.org).

Once the appeal of the Coverage Determination Request decision has been properly submitted and obtained by Louisiana Health Cooperative, the request will follow the appeals process described in *Section 7: Reconsiderations (Appeals) and Grievances.*
Section 12: Definitions and Abbreviations

Definitions

The following terms as used in this Provider Manual shall be construed and/or interpreted as follows, unless otherwise defined in the participation Agreement you have with Louisiana Health Cooperative.

“Appeal” means a request for review of some action taken by or on behalf of Louisiana Health Cooperative.

“Benefit Plan” means a health benefit policy or other health benefit contract or coverage document issued by Louisiana Health Cooperative. Benefit plans and their designs are subject to change periodically.

“Clean Claim” means a claim for Covered Services provided to a member that (a) is received timely by Louisiana Health Cooperative, (b) has no defect, impropriety, or lack of substantiating documentation from the member’s medical record regarding the Covered Services, (c) is not subject to coordination of benefits or subrogation issues, (d) is on a completed, legible 1500 form or UB-04 form or electronic equivalent that follows HIPAA standards and additional Louisiana Health Cooperative-specific requirements, including all then current guidelines regarding coding and inclusive code sets, and (e) determine payor liability, and ensure timely processing and payment by Louisiana Health Cooperative. A clean claim does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

“Co-Surgeon” means one of multiple surgeons who work together as primary surgeons performing distinct part(s) of a surgical procedure.

“Covered Services” means medically necessary health care items and services covered under a benefit plan.

“Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

“Encounter Data” means encounter information, data and reports for Covered Services provided to a member that meets the requirements for clean claims.
“Formulary” means a list of covered drugs selected by Louisiana Health Cooperative in consultation with a team of health care providers on the Pharmacy and Therapeutics (P&T) Committee, which represents the prescription therapies believed to be a necessary part of a quality treatment program.

“Grievance” means any complaint or dispute, other than one that involves a Louisiana Health Cooperative determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of Louisiana Health Cooperative, regardless of whether remedial action can be taken. Grievances may include, but are not limited to, complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item.

“Ineligible Person” means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) Federal procurement or nonprocurement programs, as may be identified in the Excluded Parties List System maintained by the General Services Administration, (b) has been convicted of a criminal offense subject to OIG’s mandatory exclusion authority for Federal Health Care Programs described in Section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in State medical assistance programs, including Medicaid or CHIP, or State procurement or nonprocurement programs as determined by a State Governmental Authority.

“Medically Necessary” or “Medical Necessity” means those health care items or services that are (i) necessary to protect life, prevent significant illness or significant disability or to alleviate severe pain, (ii) individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the member’s needs, (iii) consistent with generally accepted professional medical standards and not experimental or investigational, (iv) reflective of the level of service that can be provided safely and for which no equally effective and more conservative or less costly treatment is available statewide, (v) provided in a manner not primarily intended for the convenience of the member, the member’s caretaker or the health care provider. For health care items and services provided in a hospital on an inpatient basis, “medically necessary” also means that such items and services cannot, consistent with the provisions of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient facility of a different type. The fact that a health care provider has prescribed, recommended or approved health care items or services does not, in itself, make such items or services medically necessary.

“Member” means an individual properly enrolled in a benefit plan and eligible to receive Covered Services at the time such services are rendered.

“Member Expenses” means copayments, coinsurance, deductibles or other cost share amounts, if any, that a member is required to pay for Covered Services under a benefit plan.
“Members with Special Health Care Needs” means adults and children who face daily physical, mental or environmental challenges that place their health at risk and whose ability to fully function in society is limited.

“PCP” means a primary care provider.

“Provider” means an individual or entity that has contracted, directly or indirectly, with Health Plan to provide or arrange for the provision of Covered Services to members under a benefit plan.

“Reopening” means a remedial action taken to reconsider a final determination or decision even though the determination or decision was correct based on the evidence of record.
Abbreviations

ACS - American College of Surgeons
AEP – Annual Enrollment Period
PPA— Provider Participation Agreement
AHP – Allied Health Professional
AIDS - Acquired Immune Deficiency Syndrome
ALJ – Administrative Law Judge
AMA – American Medical Association
ARNP – Advanced Registered Nurse Practitioner
CAD – Coronary Artery Disease
CAHPS – Consumer Assessment of Healthcare Providers and Systems
CDSC – Controlled Dangerous Substance
CHF – Congestive Heart Failure
CIA – Corporate Integrity Agreement
CLAS – Culturally and Linguistically Appropriate Services
CNM – Certified Nurse Midwife
COB – Coordination of Benefits
COPD – Chronic Obstructive Pulmonary Disease
CORF – Comprehensive Outpatient Rehabilitation Facility
CSR – Controlled Substance Registration
DDE – Direct Data Entry
DEA – Drug Enforcement Agency
DM – Disease Management
DME – Durable Medical Equipment
DOC – Delegation Oversight Committee
DSM-IV - Diagnostic and Statistical Manual of Mental Disorders
DSNP – Dual-Eligible Special Needs Plans
EDI – Electronic Data Interchange
EOB – Explanation of Benefits
EOP – Explanation of Payment
ESRD – End Stage Renal Disease
FBDE – Full Benefit Dual-Eligible Members
FDA – Food and Drug Administration
FFS – Fee-For-Service
FWA – Fraud, Waste, and Abuse
HEDIS® - Healthcare Effectiveness Data and Information Set
HHA – Home Health Agency
HHS – US Department of Health and Human Services
HIPAA – Health Insurance Portability and Accountability Act of 1996
HIV – Human Immunodeficiency Virus
HMO – Health Maintenance Organization
HMO-POS – Health Maintenance Organization with Point of Service Option
HOS – Medicare Health Outcomes Survey
HRA – Health Risk Assessment
HTN – Hypertension

ICD-9/ICD-10 - International Classification of Diseases, Ninth and Tenth Edition

ICP – Individualized Care Plans

ICT – Interdisciplinary Care Team

INR – Inpatient Nursing Rehabilitation Facility

IPA – Independent Physician Association

IRE – Independent Review Entity

IVR – Interactive Voice Response

JNC – Joint National Committee

LCSW – Licensed Clinical Social Worker

LTAC – Long Term Acute Care Facility

MOC – Model of Care

MOOP – Maximum Out of Pocket

NCCI – National Correct Coding Initiative

NDC – National Drug Codes

NIH – National Institutes of Health

NPI – National Provider Identifier

NPP – Notice of Privacy Practice

OA – Osteopathic Assistant

OB – Obstetric / Obstetrical / Obstetrician

OIG – Office of Inspector General

OT – Occupational Therapy
OTC – Over-The-Counter

P&T – Pharmacy and Therapeutics Committee

PA – Physician Assistant

PCP – Primary Care Provider

PHI – Protected Health Information

POS – Point of Service

PPC – Provider-Preventable Condition

Provider ID – Provider Identification Number

PT – Physical Therapy

QDWI – Qualified Disabled Working Individual

QI – Qualifying Individual

QI Program – Quality Improvement Program

IRO – Quality Improvement Organization

RN – Registered Nurse

SFTP – Secure File Transfer Protocol

SIE – Site Inspection Evaluation

SNF – Skilled Nursing Facility

SNIP – Strategic National Implementation Process

SSN – Social Security Number

ST – Speech Therapy

Tax ID / TIN – Tax Identification Number
TNA – Transition Needs Assessment

TOC – Transition of Care

UM – Utilization Management

WEDI - Workgroup for Electronic Data Interchange