SECTION 4: MEDICAL MANAGEMENT

of the Professional Provider Office Manual

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This section provides information about medical management. If Blue Cross and Blue Shield of Louisiana makes any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this section and notify our network providers. For complete Professional Provider Office Manual information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.lablue.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.lablue.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail our policies. Louisiana Blue retains the right to add to, delete from and otherwise modify the Professional Provider Office Manual as needed. This manual and other information and materials provided are proprietary and confidential and may constitute trade secrets.

Section 4: MEDICAL MANAGEMENT

OVERVIEW

Medical management is a system for a comprehensive approach to healthcare delivery. Louisiana Blue established the Care Management Department to ensure that our members receive the highest-quality healthcare that is medically appropriate and cost effective. See the end of this section for an overview of our Quality Management Program.

UTILIZATION REVIEW ORGANIZATION

Louisiana Blue is authorized as a Utilization Review Organization (URO) and therefore follows the regulations promulgated by the Louisiana Department of Insurance that govern these entities. However, certain employer groups, primarily self-funded employer groups and the Federal Employee Plan, are not subject to the legislation that created these regulations. Since Louisiana Blue handles a wide range of fully funded and self-funded employer groups, it is not possible to have a uniform policy in all instances. The following sections note where differences occur.

PROVIDER RESPONSIBILITIES

When a provider requests a service authorization on behalf of the member, they are expected to notify the member of the Louisiana Blue authorization determination. Louisiana Blue communicates approval and denial of prior authorization requests to practitioners via the electronic authorization portal. It is the responsibility of the practitioner to check the portal regularly for electronic notification of authorization request determinations.

Method and Timelines of Practitioner Utilization Management Determination Notification

Review Type	Verbal Notification	Written Notification
Urgent Pre-Service		
Approval	N/A	Electronic Within 72 hours (Fax on request)
Denial	Within 72 hours	Electronic Within 72 hours (Fax on request)
Urgent Concurrent		
Approval	N/A	Electronic Within 72 hours (Fax on request)
Denial	Within 72 hours	Electronic Within 72 hours (Fax on request)
Non-urgent Pre-Service		
Approval	N/A	Electronic Within 15 Calendar Days (Fax on request)
Denial	Within 15 Calendar Days	Electronic Within 15 Calendar Days (Fax on request)
Pre Claim Submission Retrospective		
Approval	N/A	Electronic Within 30 Calendar Days (Fax on request)
Denial	N/A	Electronic Within 30 Calendar Days (Fax on request)
Post Claim Submission Retrospective		
Approval	N/A	Mailed Within 30 Calendar Days
Denial	N/A	Mailed Within 30 Calendar Days

CONCURRENT REVIEW

The Concurrent Review Unit evaluates the medical and service needs of patients admitted to an inpatient facility. Concurrent Review promotes and works to ensure optimal outcomes, continuity of care, development of a timely discharge plan and ongoing quality of care.

Note: In-state acute care facilities with a reimbursement method of anything other than per diem are not required to perform concurrent reviews. These facilities are only required to submit clinical information for the initial review and, upon discharge, provide a discharge disposition and discharge diagnosis.

The concurrent review nurse is the central focus and link of communication between a hospitalized member, the provider and the Care Management Department. Concurrent Review nurses conduct a review of all new admissions or continued care cases prior to the end of an approved length of stay. Concurrent Review nurses use clinical information made available and nationally recognized criteria to authorize extensions for additional inpatient care. If the Concurrent Review nurse is not able to authorize an extension based on medical necessity with the clinical information made available and the criteria, the case is referred to a medical director for a determination.

Louisiana Blue has streamlined its processes for requesting authorizations by requiring all prior authorization requests, with the exception of transplants and most out of state services, to be submitted exclusively through the Louisiana Blue Authorizations application available on iLinkBlue (for more information, see the Authorization Application Mandate entry in this manual section). This includes all levels of care, such as acute, skilled nursing and rehabilitation services.

This change allows providers to request authorization for services 24 hours a day, seven days a week, in real time. All inpatient care facilities are required to use the Louisiana Blue Authorizations application to request additional services or days with the exception of transplant cases and out of state services. A Concurrent Review nurse, in collaboration with the medical director, will conduct a review of the information provided to document the medical necessity for continued stay.

A decision is made within one business day of receiving all necessary information from the provider. If the decision is to approve the continued stay or course of treatment, the provider rendering the service is notified via telephone, fax or portal. If a decision to deny the continued stay or course of treatment is made, the provider rendering the service is immediately notified and given the reason for the denial and the procedure for initiating the appeal process.

Self funded employer groups will generally be handled in the same way as fully insured groups for operational efficiency. Insureds not subject to Utilization Review Organization (URO) regulations may have denial determinations issued on a retrospective basis if a review is not requested prior to discharge from service or prior to receipt of the initial claim for payment.

RETROSPECTIVE REVIEW

The Retrospective Review Unit reviews claims to ensure that the services rendered were medically appropriate and meet the definition of covered services under the Subscriber Contract/Certificate. A retrospective review may be performed to assess the medical need and correct billing level for services that have already been performed. As part of this review process, staff members examine diagnoses, treatments or procedures.

For retrospective authorization requests, upload medical records and the Retrospective Review Authorization Form in iLinkBlue, using the document upload feature. Click on the "Document Upload" link on the homepage, then select "Medical Records for Retrospective or Post Claim Review" from the department dropdown. The Retrospective Review Authorization Form is available online at www.lablue.com/providers, click "Resources" and then "Forms."

When a provider does not obtain authorization for certain services, our Medical Management Department reviews claims if the member's policy allows for retrospective review. Do not submit a request for retrospective review if you have already filed a claim. If we require additional medical records, Medical Management will request them using the Medical Records Request for Claim Review Form.

Some policies apply penalties for failing to request prior authorization for specific services. Other policies will not cover a service without prior authorization. If you are unsure if a policy allows for retrospective review, contact the Customer Care Center at the number found on our Quick Reference Guide in the front of this manual.

You may request a retrospective review in one of two ways:

- Fax the Retrospective Review Authorization Form to the Medical Management retrospective authorization fax number found on our Quick Reference Guide.
- Upload the Retrospective Review Authorization Form and medical records through iLinkBlue (www.lablue.com/ilinkblue). Click on the "Document Upload" link on the homepage, then select "Medical Records for Retrospective or Post Claim Review" from the department dropdown.

PEER TO PEER

Louisiana Blue has a process that allows providers to discuss utilization management decisions with our medical directors. A peer to peer is the provider's telephone request to speak to a medical director or peer reviewer on a member's behalf about a utilization management decision that Louisiana Blue has made. A peer to peer may also include submission of additional information prior to or after the peer-to-peer discussion. A peer to peer is available once and only for initial or concurrent review determinations that are requested within 10 days of the denial.

Recording Peer-to-Peer Discussions

Recording of peer-to-peer discussions with a Louisiana Blue medical director by providers is prohibited under company policy.

AUTHORIZATION PROCESS

The authorization process ensures that members receive the highest level of benefits to which they are entitled and that the most appropriate setting and level of care for a given medical condition are provided.

A Louisiana Blue nurse reviews all pertinent information submitted by providers and applies defined criteria to determine if a service is medically appropriate. The criteria used by the nurses is reviewed and approved by physicians at least annually, and more often if indicated. If the information received from a provider varies from the defined criteria, a nurse will forward the information for review by a Louisiana Blue physician.

Authorization Application Mandate

Providers must submit prior authorization requests, including new and extension authorizations, through our online Louisiana Blue Authorizations application. Louisiana Blue will not accept authorization requests via phone or fax, with a few exceptions.

- Newborn Sick Babies or "Temporary Members": A newborn sick baby often requires services that cannot be attributed to the mother's hospital stay. Parents have 30 days to add babies to a current plan or to sign them up for their own plan and eligibility is often not visible right away. Providers may call to set up the initial authorization. Once Louisiana Blue completes the initial setup of the baby as a temporary member for authorization purposes only, providers must then access the Louisiana Blue Authorizations application to upload clinical reviews.
- Most Out of State Providers (OOS): Authorizations for out-of-state services performed by out-of-state providers should be requested by phone or fax.
- Transplant Authorizations: Requests for transplant evaluations, listings and the actual transplant should be called or faxed to the Louisiana Blue Authorizations Department.
- Dental Services Covered Under Medical: Dentist performing services that are covered under medical should be called or faxed to the Louisiana Blue Authorizations Department.

With our online process you have the capability to get an immediate approval without Louisiana Blue personnel intervention. Please remember, if the requested services are to treat a condition that may arise from a complication of a noncovered service, claims will be denied as noncovered regardless of medical necessity. Providers are responsible for checking member eligibility and benefits.

An example of this would be a member experiencing complications after a noncovered gastric bypass. These complications would not be covered under the member's policy regardless of medical necessity, even if an authorization is obtained via the Louisiana Blue Authorizations application. If you have a situation similar to this example, please submit the clinical information via the Louisiana Blue Authorizations application for a review, rather than applying InterQual (IQ) criteria.

Providers can supply the necessary clinical information in one of the three ways outlined below:

- Complete criteria review via IQ. Some services will require additional review, such as a benefit review or a medical policy review regardless of an IQ approval. Completing an IQ review is not required. Note: Inpatient requests will not get an automatic approval due to system limitations. Inpatient requests are reviewed by Louisiana Blue.
- Upload clinical information to the authorization request through the Louisiana Blue Authorizations application. Use the notes section on the Diagnoses/Services screen in the application when completing the initial request. Choose the most appropriate Note Type to ensure correct distribution of the request.
- Document the clinical information in the notes section of the authorization request in the Louisiana Blue Authorizations application. Once an authorization request is submitted, to communicate with Louisiana Blue (i.e., request a peer-to-peer review, request additional bed days/services or add clinical information), click on "Add Note/Attachment" in the Referral Details screen for that case.

Authorization Application Resources

For information on how to use our Louisiana Blue Authorizations application, please refer to the *Louisiana Blue Authorizations Applications User Guide*, available on iLinkBlue under the "Resources" tab, then click "Manuals." For information on using iLinkBlue, refer to the *iLinkBlue User Guide*, available at www.lablue.com/providers, click "Resources," then "Manuals."

Vendor Authorizations Visible in Louisiana Blue's Authorization Application

Providers can view some vendor authorizations and their status in the Louisiana Blue Authorizations application. This applies to Carelon Medical Benefits Management (Carelon) authorizations and Express Scripts Inc. targeted medical drug authorizations finalized on or after Aug. 1, 2026. Express Scripts pharmacy drug authorizations are not visible in the application. Visibility of vendor authorizations in the application is view only and does not change authorization processes.

Providers must still contact vendors for authorizations when applicable. Any edits to these authorizations should also continue to go to the vendor. This includes all vendor functions such as peer-to-peer contacts, dates of service changes, code updates, provider updates, etc.

Inpatient vendor authorizations are also visible in the Louisiana Blue Authorizations application. Facilities should follow the process for requesting continued stays and providing discharge notifications through the application for authorizations that are visible in the Louisiana Blue Authorizations application.

Approval and denial letters affiliated with vendor authorizations are not visible in the Louisiana Blue Authorizations application at this time.

Pre-Service Authorizations – Louisiana Blue

A preservice authorization is the review and authorization of a procedure prior to the service being rendered. The medical necessity and appropriateness of selected surgical procedures, selected diagnostic procedures and various other services are reviewed prior to the service being performed. A listing of services that require authorization is provided in this manual. Authorization requirements may vary slightly by product. The following describes the process and procedural steps for obtaining pre-service authorizations:

- The provider must initiate the authorization process at least 48 hours prior to the service by:
  - Submitting an authorization request using the authorization applications available on iLinkBlue, or
  - Calling the appropriate authorization number on the member ID card for services excluded from being loaded via the Louisiana Blue Authorizations application.
- The following information is required to complete a pre-service authorization:
  1. Patient/member name, date of birth, member ID number;
  2. Provider's name, National Provider Identifier (NPI), address and telephone number;
  3. Name of the facility at which the service will be rendered;
  4. Anticipated date of service;
  5. Requested length of stay (if applicable);
  6. Diagnosis (to include ICD-10-CM codes), procedures (CPT and HCPCS codes), plan of treatment, medical justification for services or supplies and complications or other factors requiring the requested setting; and
  7. Name and phone number of person requesting authorization.
- The initial request received prior to a scheduled inpatient admission or outpatient procedure is classified as a pre-service authorization. Decisions are made according to accreditation, federal and local law.
- If the request is approved, the contact person is notified within 24 hours of the determination. Confirmation for continued hospitalization or services includes the date of admission or onset of services, the number of extended days or units of service, the next anticipated review point and the new total number of days or services approved. Types of notification include verbal (by telephone at the time of the call) voicemail, web or electronic means including email and fax. A letter of confirmation is mailed to the member and faxed to the provider and hospital, if applicable, within two working days of the decision being made.
- If the decision is to noncertify the authorization, the contact person is notified of the principal reasons for determination not to certify and appeal rights verbally (by telephone or voicemail) within 24 hours of the determination. A noncertification letter is sent to the member, physician and hospital, if applicable, within one working day of the decision. The letter will list appeal rights based on regulatory guidelines.

Urgent Care Authorizations – Louisiana Blue

- The initial request for authorization of an urgent illness is processed as soon as possible based on the clinical situation, or within 72 hours of the request regardless of whether all information is received. If the supporting clinical information is not submitted, the urgent request will be denied after 72 hours for lack of information. Clinical information can be provided via your normal process to the original case.
- If the request is approved, the contact person/practitioner is notified by telephone and/or a confirmation letter is mailed to the member and sent via Tapestry Link In Basket accessed in the Louisiana Blue Authorizations application or faxed to the provider and hospital, if applicable.
- If the request is denied, the contact person is notified by telephone and is given the reason for the denial and the procedure for initiating the appeal process. A letter is sent to the member, physician and hospital, if applicable, within one business day of the determination. The notification will list appeal rights based on regulatory guidelines.

The authorization process is designed only to evaluate the medical necessity of the service. AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT OR A CONFIRMATION OF COVERAGE FOR BENEFITS. Payment of benefits remains subject to all other Subscriber Contract/Certificate terms, conditions, limitations, exclusions and the patient's eligibility for benefits at the time expenses are incurred. Check an individual's benefits, limitations and eligibility immediately prior to providing a benefit or service. You may log into iLinkBlue or call the Customer Service number on the member ID card for specific information.

Notification of Admission/Status Change

Occasionally, it may be necessary to change or cancel a service, or the circumstances may require an adjustment to the anticipated length of stay. When a change in the nature, duration or reasons for an authorized service occurs, the provider should notify the Authorization Unit by accessing the case via the Louisiana Blue Authorizations application. To communicate with Louisiana Blue, request additional bed days/services or add clinical information, click on "Add Note/Attachment" in the Referral Details screen for that case. Choose the most appropriate "Note Type." This will help prevent confusion and unnecessary delay or errors when processing claims for services associated with the service.

Routine Maternity Admissions

Inpatient hospital admission in connection with childbirth does not require authorization, except for Office of Group Benefits (OGB) members. Inpatient services for newborn well-baby services are included in the mother's stay. However, authorization is required for inpatient sick-baby services.

Admissions in connection with childbirth for OGB members to in-network or out-of-network facilities will require authorization if the inpatient stay is more than 48 hours for vaginal delivery and more than 96 hours for caesarean section delivery.

Home Health Authorizations

Home health providers are required to request all authorizations for home health services through the Louisiana Blue Authorizations application on iLinkBlue. Authorizations for home health services will not be taken via phone or fax unless one of the exceptions to the Authorizations Application Mandate applies. This includes new service requests and extensions.

Providers will need to supply the necessary clinical information in one of the three ways outlined below:

- Complete a criteria review via InterQual (IQ). Completing an IQ review is not required, but if one is completed and criteria is met the provider may receive approval online. Some self-funded members will not get an automatic approval due to benefit limits.
- Upload clinical information to the authorization request through the Louisiana Blue Authorizations application.
- Document the clinical information in the notes section of the request in the Louisiana Blue Authorizations application. This option requires the provider to click on "Add Note/Attachment" in the Referral Details screen for that case. Select "Provider Clinical Information" as the Note Type.

Process for Changing a Louisiana Blue Authorization

You can ask our Authorization Department to change or add a code to an already approved authorization when all of the following conditions are met:

- There is an approved authorization on file.
- Provider states a claim has not been filed.
- The requested code is surgical or diagnostic.
- The requested code or service is not on a Louisiana Blue medical policy or is a non-covered benefit.

If the above criteria are met, an authorization can be changed within seven calendar days of the services being rendered. This can be done in the Louisiana Blue Authorizations application by clicking on "Add Note/Attachment" in the Referral Details screen for that case. Select "Provider Clinical Information" as the Note Type.

Note: If the procedure being added or changed is affiliated with a Louisiana Blue medical policy or is a noncovered benefit, the additional codes or services requested would go through the normal review process.

The Gold Card Program

Louisiana Blue implemented a Gold Card Program for certain services that require authorization. This program is designed to help lessen the administrative burdens for providers meeting the established criteria.

Participating providers who meet the below program criteria receive the following benefits.

Provider Type	Participation Criteria	Gold Card Program Benefit
Professional Providers	• Has a volume of at least 50 high-tech imaging service requests per year. • Maintains an authorization approval rating of 95–99%.	Always receives an approval for the following high-tech imaging authorization requests: • Computerized Tomography (CT) Scans • Magnetic Resonance Imaging (MRI) • Magnetic Resonance Angiography (MRA) • Nuclear Cardiology Procedures • Positron-Emission Tomography (PET) Scans
Facilities	• Is a diagnostic related group (DRG) inpatient acute care facility; or • Is an inpatient acute care facility that has a percent of billed charges agreement with Louisiana Blue • Louisiana Blue does not consider the following facilities for the Gold Card Program: - Per-diem inpatient acute care - Inpatient rehabilitation - Skilled nursing - Long-term acute care	No longer needs to perform continuation or concurrent reviews for acute inpatient stays.

The Gold Card Program applies to high-tech imaging and inpatient acute authorization requests made for Louisiana Blue and HMO Louisiana Inc. members.

Professional providers participating in the high-tech imaging Gold Card Program must continue to submit authorization requests to allow for claim payments. Louisiana Blue also needs this information for audit purposes to evaluate continued participation in the program annually. Submit high-tech imaging requests through the Carelon Authorizations application available through iLinkBlue (www.lablue.com/ilinkblue). Services authorized by Louisiana Blue rather than Carelon should be submitted through the Louisiana Blue Authorizations application in iLinkBlue. Louisiana Blue will always approve the authorization for the high-tech imaging service.

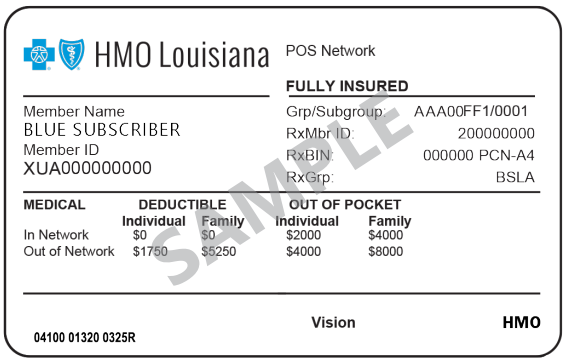
If your case is selected for audit, you will see a message at the top of the Carelon page directing you to upload additional documentation that supports the medical necessity of the request. If you do not submit the requested additional documentation for the audit case, we will consider the case "audit criteria not met." Failure to participate or to pass the audit will result in loss of future Gold Card status. Note: Providers must request at least 50 cases during the Gold Card period to continue participation.

Facilities participating in the Gold Card Program are required to perform notification and current review activities for the initial-day(s) approval. Continue to notify your Louisiana Blue Utilization Management contact of discharge date and discharge diagnosis. Louisiana Blue needs this information to reimburse the inpatient stay. Complete these activities in the Louisiana Blue Authorizations application in iLinkBlue.

AUTHORIZATION PENALTIES FOR PROVIDERS

Outpatient Authorization Penalty

For Fully Insured PPO and HMO/POS Members:
Penalties for failure to obtain an authorization prior to performing outpatient services that require authorization will be 30%. This penalty will be applied to the network provider's benefit payment of the allowable charge. The network provider is responsible for the penalty amount and agrees to hold the member harmless for such penalties incurred. The member is responsible for any applicable copayment, deductible, coinsurance percentage and/or noncovered services. This does not apply to PPO providers of other Blue Plans.



For Fully Insured HMO/HMO Members and OGB Members:
Failure to obtain prior authorization of service(s) will result in a claim denial.

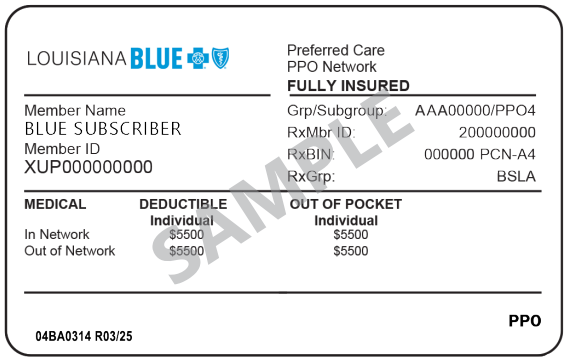
For Self Funded PPO and HMO Members:
Authorization requirements vary for self funded members. Penalties for failure to obtain an authorization prior to performing outpatient services that require authorization will be 30%.

For self-funded members in a plan with an exclusive provider organization (EPO) network tier (excluding certain Select Network products), there is no penalty for failure to obtain an authorization prior to performing outpatient services if the EPO network is comprised of the self-funded plan's own employees.

Always verify authorization requirements and benefits on iLinkBlue, prior to rendering services.

Inpatient Authorization Penalty

For Fully Insured PPO and HMO/POS Members:
For Louisiana Blue or HMO Louisiana, a $1,000 penalty will be applied to inpatient hospital claims if the network provider fails to obtain authorization for the services prior to the inpatient admission. This penalty will be applied to inpatient stays of members covered by any Blue Plan or subsidiary when the member's policy requires a pre-service authorization, and the provider agrees to hold the member harmless for such penalties incurred.



When a member is covered by a policy issued by another (non-Louisiana) Blue Plan or subsidiary, and the member's policy contains a different penalty for failure to authorize an inpatient stay, this $1,000 penalty provision will be applied before the terms of the member's policy.

For Fully Insured HMO/HMO Members and OGB Members:
Failure to authorize service(s) will result in a claim denial. OGB does not authorize Louisiana Blue to reconsider these denials at the appeal level.

For Self Funded PPO and HMO/POS Members:
For Louisiana Blue or HMO Louisiana, a $1,000 penalty will be applied to inpatient hospital claims if the network provider fails to obtain authorization for the services prior to the inpatient admission.

For self-funded members in a plan with an EPO network tier (excluding certain Select Network products), there is no penalty for failure to obtain an authorization prior to performing inpatient services if the EPO network is comprised of the self-funded plan's own employees.

When a member is covered by a policy issued by another (non-Louisiana) Blue Plan or subsidiary, and the member's policy contains a different penalty for failure to authorize an inpatient stay, this $1,000 penalty provision will be applied prior and in addition to application of any penalty in the terms of the member's policy.

PPO SERVICES THAT REQUIRE PRIOR AUTHORIZATION

The following services may require Louisiana Blue approval. This list may vary for self-funded groups. Dollar amounts are based on billed charges.

Preferred Care PPO

- Air Ambulance – Non-emergent (no benefit without prior authorization)
- Applied Behavior Analysis
- Arterial Ultrasound*
- Arthroscopy and Open Procedures (shoulder & knee)*
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cardiac Resynchronization Therapy*
- Cardiac Rhythm Monitors*
- Cellular Immunotherapy (no benefit without written authorization)
- Compound Drugs greater than $250
- Coronary Arteriography*
- CT Scans*
- Day Rehabilitation Programs
- Electric & Custom Wheelchairs
- Gene Therapy (no benefit without written authorization)
- Genetic or Molecular Testing*
- Hip Arthroscopy*
- Hearing Aids age 18 & older (no benefit without prior authorization)
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Cardioverter Defibrillators*
- Implantable Medical Devices over $2,000 (excludes cardiac devices such as defibrillators, cardioverters, pacemakers)
- Inpatient Hospital Services (except those in connection with childbirth)
- Intensive Outpatient Programs
- Interventional Spine Pain Management*
- Joint Replacement (hip, knee & shoulder)*
- Low-protein Food Products
- Meniscal Allograft Transplantation of the Knee*
- MRI/MRA*
- Nuclear Cardiology*
- Partial Hospitalization Programs
- Percutaneous Coronary Interventions such as Coronary Stents and Balloon Angioplasty*
- Peripheral Revascularization*
- Permanent Implantable Pacemakers*
- PET Scans*
- Certain Prescription Drugs – the complete list of drugs requiring an authorization is available online at www.lablue.com/providers >Pharmacy
- Private Duty Nursing
- Prosthetic Appliances
- Pulmonary Rehabilitation
- Radiation Therapy*
- Residential Treatment Centers
- Resting Transthoracic Echocardiography*
- Sleep Apnea Diagnostics and Titration* (Home sleep test (HST), Polysomnograms (PSG), Multiple sleep latency testing (MSLT), Maintenance of wakefulness testing (MWT), Positive airway pressure titration studies)
- Sleep Apnea Treatment* (Automatic positive airway pressure (APAP) therapy, Continuous positive airway pressure (CPAP) therapy, Bilevel or variable positive airway pressure (BPAP) therapy. Includes all supplies related to these devices, Oral appliance therapy and Hypoglossal nerve stimulation therapy)
- Spine Surgery*
- Stress Echocardiography*
- Surgical Treatment of Erectile Dysfunction (including penile implants) (if benefits available)
- Temporomandibular Joint Syndrome (TMJ) Surgical Treatment
- Transesophageal Echocardiography*
- Transplant Evaluation & Transplants (no benefit without written authorization)
- Treatment of Osteochondral Defects
- Vacuum Assisted Wound Closure Therapy
- Wearable Cardioverter*

To Request Prior Authorization

Please use the authorization applications that are available on iLinkBlue (www.lablue.com/ilinkblue). They are located under the "Authorizations" menu option. Louisiana Blue no longer accepts authorization requests via phone or fax. Exceptions include transplants, dental services covered under medical and most out-of-state services. Providers must submit prior authorization requests, including new and extension authorizations through our online Louisiana Blue Authorizations application.

* High-tech imaging and Utilization Management program services are authorized through the Carelon Medical Benefits Managemen (MBM) Provider Portal by clicking the "Carelon Authorizations" link.

Penalties may apply for failure to obtain prior authorization.

HMO SERVICES THAT REQUIRE PRIOR AUTHORIZATION

The following services and/or procedures may require HMO Louisiana approval. This list may vary for self-funded groups. Dollar amounts are based on billed charges.

HMO Louisiana, Blue Connect, BlueHPN, Community Blue, Precision Blue, Signature Blue and Bridge Blue

- Air Ambulance – Non-emergent (no benefit without prior authorization)
- Applied Behavior Analysis
- Arterial Ultrasound*
- Arthroscopy and Open Procedures (shoulder & knee)*
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cardiac Resynchronization Therapy*
- Cardiac Rhythm Monitors*
- Cellular Immunotherapy (no benefit without written authorization)
- Compound Drugs greater than $250
- Coronary Arteriography*
- CT Scans*
- Day Rehabilitation Programs
- Durable Medical Equipment greater than $325 (total billed amount exceeds $325)
- Electric & Custom Wheelchairs
- Gene Therapy (no benefit without written authorization)
- Genetic or Molecular Testing*
- Hearing Aids age 18 & older (no benefit without prior authorization)
- Hip Arthroscopy*
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Cardioverter Defibrillators*
- Implantable Medical Devices over $2,000 (excludes cardiac devices such as defibrillators, cardioverters, pacemakers)
- Inpatient Hospital Services (except those in connection with childbirth)
- Intensive Outpatient Programs
- Interventional Spine Pain Management*
- Joint Replacement (hip, knee & shoulder)*
- Low-protein Food Products
- Meniscal Allograft Transplantation of the Knee*
- MRI/MRA*
- Nuclear Cardiology*
- Oral Surgery (not required when performed in an office)
- Orthotic Devices greater than $325 (total billed amount exceeds $325)
- Partial Hospitalization Programs
- Percutaneous Coronary Interventions such as Coronary Stents and Balloon Angioplasty*
- Peripheral Revascularization*
- Permanent Implantable Pacemakers*
- PET Scans*
- Certain Prescription Drugs – the complete list of drugs requiring an authorization is available online at www.lablue.com/providers > Pharmacy
- Private Duty Nursing
- Prosthetic Appliances
- Pulmonary Rehabilitation
- Radiation Therapy*
- Residential Treatment Centers
- Resting Transthoracic Echocardiography*
- Sleep Apnea Diagnostics and Titration* (Home sleep test (HST), Polysomnograms (PSG), Multiple sleep latency testing (MSLT), Maintenance of wakefulness testing (MWT), Positive airway pressure titration studies)
- Sleep Apnea Treatment* (Automatic positive airway pressure (APAP) therapy, Continuous positive airway pressure (CPAP) therapy, Bilevel or variable positive airway pressure (BPAP) therapy. Includes all supplies related to these devices, Oral appliance therapy and Hypoglossal nerve stimulation therapy)
- Spine Surgery*
- Stress Echocardiography*
- Surgical Treatment of Erectile Dysfunction (including penile implants) (if benefits available)
- Temporomandibular Joint Syndrome (TMJ) Surgical Treatment
- Transesophageal Echocardiography*
- Transplant Evaluation & Transplants (no benefit without written authorization)
- Treatment of Osteochondral Defects*
- Vacuum Assisted Wound Closure Therapy
- Wearable Cardioverter*

To Request Prior Authorization

Please use the authorization applications that are available on iLinkBlue (www.lablue.com/ilinkblue). They are located under the "Authorizations" menu option. Louisiana Blue no longer accepts authorization requests via phone or fax. Exceptions include transplants, dental services covered under medical and most out-of-state services. Providers must submit prior authorization requests, including new and extension authorizations through our online Louisiana Blue Authorizations application.

* High-tech imaging and Utilization Management program services are authorized through the Carelon MBM Provider Portal by clicking the "Carelon Authorizations" link.

Penalties may apply for failure to obtain prior authorization.

OGB PLAN SERVICES THAT REQUIRE PRIOR AUTHORIZATION

Plan authorization is required for the following services for all OGB benefit plans when the OGB plan is primary or secondary. When Medicare is primary, an authorization is required for occupational therapy greater than 50 visits, physical therapy greater than 50 visits and bariatric surgery benefit (enrollment and surgery). Failure to obtain prior authorization for these services will result in the denial of payment for services.

Authorization requirements for the following services apply for all OGB benefit plans.

INPATIENT

- Hospital Admissions (except routine delivery stays)
- Mental Health/Substance Use Disorder Admissions
- Organ, Tissue and Bone Marrow Transplant Services
- Skilled Nursing Facility

OUTPATIENT

- Air Ambulance – Non-Emergent (no benefit without prior authorization)
- Applied Behavior Analysis
- Arterial Ultrasound*
- Arthroscopy and Open Procedures (shoulder & knee)*
- Bariatric Benefit (enrollment & surgery)
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cardiac Resynchronization Therapy*
- Cardiac Rhythm Monitors*
- Cellular Immunotherapy
- Coronary Arteriography*
- CT Scans*
- Day Rehabilitation Programs
- Durable Medical Equipment greater than $325 (total billed amount exceeds $325)
- Electric & Custom Wheelchairs
- Gene Therapy
- Genetic and Molecular Testing*
- Hip Arthroscopy*
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Cardioverter Defibrillators*
- Implantable Medical Devices over $2,000 (excludes cardiac devices such as defibrillators, cardioverters, pacemakers)
- Intensive Outpatient Programs
- Interventional Spine Pain Management*
- Joint Replacement (hip, knee & shoulder)*
- Low Protein Food Products
- Meniscal Allograft Transplantation of the Knee*
- MRI/MRA*
- Nuclear Cardiology*
- Oral Surgery (not required when performed in a Physician's office)
- Orthotic Devices greater than $325 (total billed amount exceeds $325)
- Partial Hospitalization Programs
- Percutaneous Coronary Interventions such as Coronary Stents and Balloon Angioplasty*
- Permanent Implantable Pacemakers*
- Peripheral Revascularization*
- PET Scans*
- Certain Prescription Drugs – the complete list of drugs requiring an authorization is available online at www.lablue.com/providers > Pharmacy
- Physical/Occupational Therapy (greater than 50 visits)
- Prosthetic Appliances (greater than $300)
- Pulmonary Rehabilitation
- Radiation Therapy*
- Residential Treatment Centers
- Resting Transthoracic Echocardiography*
- Sleep Studies (except those performed as a home sleep study)
- Spine Surgery*
- Stress Echocardiography*
- Surgical Treatment of Urinary Dysfunction or Sexual Dysfunction Resulting from Cancer or Cancer Treatment (including penile implants)
- Transesophageal Echocardiography*
- Transplant Evaluation and Transplants
- Treatment of Osteochondral Defects*
- Vacuum Assisted Wound Closure Therapy
- Wearable Cardioverter*

To Request Prior Authorization

Please use the authorization applications that are available on iLinkBlue (www.lablue.com/ilinkblue). They are located under the "Authorizations" menu option. Louisiana Blue no longer accepts authorization requests via phone or fax. Exceptions include transplants, dental services covered under medical and most out-of-state services. Providers must submit prior authorization requests, including new and extension authorizations through our online Louisiana Blue Authorizations application.

* High-tech imaging and Utilization Management program services are authorized through the Carelon MBM Provider Portal by clicking the "Carelon Authorizations" link.

For OGB members, failure to obtain prior authorization, when required, will result in the denial of payments for services.

OCHPLUS SERVICES THAT REQUIRE PRIOR AUTHORIZATION

The following services may require Louisiana Blue approval for OchPlus benefit plans. If authorization is not requested prior to admission or receiving outpatient services requiring an authorization, the plan has the right to determine if the admission or outpatient services are medically necessary. If determined not medically necessary, the admission or outpatient services will not be covered and the member will be responsible for all charges.

If the admission or outpatient services are medically necessary, benefits will be provided based on the participating status of the provider rendering the services.

OchPlus

- Air Ambulance – Non-emergent (no benefit without prior authorization)
- Applied Behavior Analysis
- Arthroscopy and Open Procedures (shoulder & knee)*
- Bariatric Surgery
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- CT Scans*
- Day Rehabilitation Programs
- Durable Medical Equipment – greater than $750
- Electric & Custom Wheelchairs
- Enteral Formula
- Gender Reassignment Services and Surgery
- Gene Therapy
- Genetic and Molecular Testing*
- Home Health Care – all charges will be denied if authorization is not obtained
- Hospice – all charges will be denied if authorization is not obtained for in-network (outpatient only) and out-of-network (inpatient and outpatient) facilities
- Hip Arthroscopy*
- Hyperbarics
- Implantable Medical Devices over $2,000 (excludes cardiac devices such as defibrillators, cardioverters, pacemakers)
- Inpatient Hospital Services (except those in connection with childbirth)
- Interventional Spine Pain Management*
- Joint Replacement (hip, knee & shoulder)*
- Meniscal Allograft Transplantation of the Knee*
- MRI/MRA*
- Nuclear Cardiology*
- Orthotic Devices – greater than $750
- PET Scans*
- Private Duty Nursing
- Prosthetic Appliances – greater than $750
- Pulmonary Rehabilitation
- Residential Treatment Centers
- Sclerotherapy for Varicose Veins
- Sleep Studies, except for those performed as a home sleep study
- Spine Surgery*
- Temporomandibular Joint Syndrome (TMJ) Surgical Treatment
- Transplant Evaluation and Transplants
- Treatment of Osteochondral Defects*
- Vacuum Assisted Wound Closure Therapy

To Request Prior Authorization

Please use the authorization applications that are available on iLinkBlue (www.lablue.com/ilinkblue). They are located under the "Authorizations" menu option. Louisiana Blue no longer accepts authorization requests via phone or fax. Exceptions include transplants, dental services covered under medical and most out-of-state services. Providers must submit prior authorization requests, including new and extension authorizations through our online Louisiana Blue Authorizations application.

* High-tech imaging and Utilization Management program services are authorized through the Carelon MBM Provider Portal by clicking the "Carelon Authorizations" link.

Penalties may apply for failure to obtain prior authorization.

FEP SERVICES THAT REQUIRE PRIOR AUTHORIZATION

Prior authorization is required for the following services for FEHB and PSHB members. Please always verify the member's eligibility, benefits and limitations prior to providing services. To do this, use iLinkBlue.

FEP Blue Standard/FEP Blue Basic

- Air Ambulance (non-emergent)
- Applied Behavior Analysis
- Blood/Marrow Stem Cell Transplants
- Certain High-Cost Drugs Obtained Outside of a Pharmacy Setting – A complete list of these drugs is available at www.fepblue.org/highcostdrugs
- Certain Prescription Drugs and Supplies (including medical foods)
- Clinical Trials for Certain Stem Cell Transplants
- Gene Therapy/Cellular Immunotherapy
- Genetic Testing
- Hearing Aids
- Inpatient Hospital Services (except routine maternity stays)
- Nonurgent Outpatient Surgical Orthopedic Procedures on the Hip, Knee and Spine
- Organ/Tissue Transplants and Transplant Travel (including autologous pancreas-islet-cell, heart, artificial heart implant, heart-lung, intestinal, liver, lung, pancreas, simultaneous liver-kidney, simultaneous pancreas-kidney; excluding cornea and kidney transplants)
- Outpatient Facility-based Sleep Studies
- Oral/Maxillofacial Procedures (except when related to an accidental injury and provided within 72 hours of the accident)
- Proton Beam Therapy
- Reproductive Services
- Residential Treatment Center
- Sperm/Egg Storage
- Stereotactic Radiosurgery
- Stereotactic Body Radiation Therapy
- Surgical Treatment for Morbid Obesity

FEP Blue Focus

- Air Ambulance (non-emergent)
- Applied Behavior Analysis
- Blood/Marrow Stem Cell Transplants
- Breast Reduction Augmentation (not related to the treatment of cancer)
- Cardiac Rehabilitation
- Certain High-Cost Drugs Obtained Outside of a Pharmacy Setting – a complete list of these drugs is available at www.fepblue.org/highcostdrugs
- Clinical Trials for Certain Stem Cell Transplants
- Certain Prescription Drugs and Supplies (including medical foods)
- Cochlear Implants
- CT Scan
- Gene Therapy/Cellular Immunotherapy
- Genetic Testing - Prior approval for genetic testing will be required when the test is being performed to assess the risk of passing a genetic condition to a child, or when the member has no active disease or signs or symptoms of the disease that is being screened
- Inpatient Hospital Services (except routine maternity stays)
- MRI
- Oral/Maxillofacial Procedures (except when related to an accidental injury and provided within 72 hours of the accident)
- Organ/Tissue Transplants (including autologous pancreas-islet-cell, heart, artificial heart implant, heart-lung, intestinal, liver, lung, pancreas, simultaneous liver-kidney, simultaneous pancreas-kidney; excluding cornea and kidney transplants)
- Orthognathic Surgery Procedures
- Orthopedic Procedures
- Outpatient Residential Treatment Center
- PET Scan
- Prosthetic Devices
- Proton Beam Therapy
- Pulmonary Rehabilitation
- Reconstructive Surgery (not related to the treatment of breast cancer)
- Reproductive Services
- Residential Treatment Center Care
- Rhinoplasty
- Septoplasty
- Specialty Durable Medical Equipment
- Sperm/Egg Storage
- Stereotactic Radiosurgery
- Stereotactic Body Radiation Therapy
- Surgical Treatment for Morbid Obesity - Benefits are only available for the surgical treatment of severe obesity when provided at a Blue Distinction® Specialty Care Center for Bariatric (weight loss) Surgery.
- Specialty DME Services
- Travel Benefits
- Varicose Vein Treatment

Failure to obtain prior authorization for these services will result in a $500 penalty for inpatient services.

Failure to obtain prior authorization for these services will result in a $100 penalty for outpatient services and a $500 penalty for inpatient services.

To Request Prior Authorization

Please use the authorization applications that are available on iLinkBlue (www.lablue.com/ilinkblue). They are located under the "Authorizations" menu option. Louisiana Blue no longer accepts authorization requests via phone or fax. Exceptions include transplants, dental services covered under medical and most out-of-state services. Providers must submit prior authorization requests, including new and extension authorizations through our online Louisiana Blue Authorizations application.

CARELON UTILIZATION MANAGEMENT PROGRAMS

Louisiana Blue has several Utilization Management programs that are administered by Carelon Medical Benefits Management (Carelon). Carelon is an independent company that serves as an authorization manager for Louisiana Blue and HMO Louisiana, Inc. members. For these programs, prior authorization requests should be made directly to Carelon using its MBM Provider Portal, which is available under the "Authorizations" section of iLinkBlue.

Ordering physicians (whether a primary care provider or specialist) are required to provide Carelon with basic clinical information and patient demographics to obtain the authorization. Primary care providers (PCPs) are not expected to obtain the authorization if a specialist orders the service. Hospitals and freestanding facilities may check the status of an authorization request through the Carelon MBM Provider Portal on iLinkBlue. They may also obtain authorization if they have all relevant information required for the authorization process.

Carelon clinical appropriateness guidelines are available online at www.guidelines.carelonmedicalbenefitsmanagement.com. If a request for authorization is denied, Carelon notifies the ordering provider of the denial and the process for appeals. A reconsideration may be requested via a peer to peer submitted directly to Carelon within 10 business days of the denial. Please allow ample time in scheduling services to ensure the authorization process is completed and approved before the patient receives services. Services that do not meet criteria will be denied and are not billable to the member.

Reminders for navigating Carelon's review process:

- If you file a claim for a service that requires prior authorization, but prior authorization was not done for the rendered service, the claim may deny with one of the following codes: WI7, WJA or WJ3. If your claim rejects advising you to contact Carelon for a medical necessity review, you must submit a new authorization request to Carelon for the service codes that were rejected and require review. Resubmit the claim after Carelon completes its review of the retrospective request.
- Provide medical records to Carelon during the review process. If you send medical records to Louisiana Blue, we will not forward them to Carelon. We will send them back to you and advise you to contact Carelon. This is because Louisiana Blue does not perform these reviews.
- You can initiate these reviews through the Carelon MBM Provider Portal, on iLinkBlue (www.lablue.com/ilinkblue) under the "Authorizations" tab, or by contacting Carelon at 1-866-455-8416.

High-tech Imaging Services Program

This program applies for the following office and outpatient, non-emergent imaging services:

- Computerized Tomography (CT) Scans
- Computerized Tomography Angiography (CTA)
- Magnetic Resonance Imaging (MRI) – Note: authorizations for CPT 70336 are handled directly by Louisiana Blue. Most member contracts do not cover this service; however, a few large employers do provide some level of coverage.
- Magnetic Resonance Angiography (MRA)
- Nuclear Cardiology Procedures
- Positron-Emission Tomography (PET) Scans

Note: Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, outpatient surgery (hospitals and freestanding surgery centers) or observation stays are not included in this high-tech imaging program.

Cardiology Program

This program applies for the following office and outpatient non-emergent services:

- Echocardiography
- Coronary Arteriography/Cardiac Catheterization (coronary arteriography/ cardiac catheterization for management of acute coronary syndrome is excluded from this program)
- Arterial Ultrasound
- Percutaneous Coronary Interventions (PCIs) such as Coronary Stents and Balloon Angioplasty
- Cardiac Resynchronization Therapy
- Implantable Cardioverter Defibrillators
- Permanent Implantable Pacemakers
- Wearable Cardioverter
- Peripheral Revascularization
- Cardiac Rhythm Monitors

Note: Providers have 10 business days post service to contact Carelon for PCI services. When contacted for an authorization within 10 business days of the service being performed, Carelon will treat the PCI request as a "prospective" case. Failure to obtain prior authorization may result in a claim denial for some contracts. Prior authorization penalties vary depending on the member's contract. Cases not obtained within 10 business days of the service being performed will be subject to authorization penalties and Carelon's post claim clinical appropriateness (PCCA) process when allowed.

Genetic Testing Program

This program applies for the following outpatient non-emergent services:

- Reproductive Carrier Screen
- Prenatal Testing
- Preimplantation Genetic Testing (PGT)
- Rare Disease Testing
- Whole Exome/Genome Sequencing
- Hereditary Cancer Testing
- Hereditary Cardiac Testing
- Tumor Testing
- Neurogenetic and Neuromuscular Testing
- Pharmacogenomics and Thrombophilia Testing
- Susceptibility Testing for Common Diseases

Musculoskeletal (MSK) Program

This program applies for the following inpatient and outpatient non-emergent services performed in certain locations:

- Interventional Pain Management (when performed in an ambulatory surgical center, physician's office or outpatient hospital)
  - Epidural steroid injections
  - Facet injections
  - Spinal cord stimulators
  - Radiofrequency ablation
- Joint Surgery (when performed in an ambulatory surgical center, inpatient hospital or outpatient hospital)
  - Joint replacement (hip, knee and shoulder)
  - Arthroscopy and open procedures (shoulder and knee)
  - Hip arthroscopy
  - Meniscal allograft transplantation of the knee
  - Treatment of osteochondral defects
- Spine Surgery (when performed in an ambulatory surgical center, inpatient hospital or outpatient hospital)
  - Bone grafts
  - Bone growth simulators
  - Cervical/lumbar spinal fusions
  - Cervical/lumbar spinal laminectomies
  - Cervical/lumbar spinal discectomies
  - Cervical/lumbar spinal disc arthroplasty (replacement)
  - Spinal deformity (scoliosis/kyphosis)
  - Vertebroplasty/kyphoplasty

Radiation Therapy Program

This program applies for the following office, outpatient and freestanding facility services:

- 2D/3D conformal radiation therapy
- Intensity-modulated radiation therapy
- Intraoperative radiotherapy (IORT)
- Stereotactic radiosurgery
- Stereotactic body radiotherapy
- Brachytherapy
- Proton beam therapy
- Hypo fractionation for bone metastases, non-small cell lung cancer and breast cancer when requesting EBRT and IMRT
- Special procedures and consultations associated with a treatment plan (CPT codes 77370 and 77470)
- Image guidance radiation therapy (IGRT)

Sleep Management Program

This program applies for the following office, outpatient hospital, freestanding outpatient facilities and home services:

- Sleep Apnea Diagnostics and Titration
  - Home sleep test (HST)
  - Polysomnograms (PSG)
  - Multiple sleep latency testing (MSLT)
  - Maintenance of wakefulness testing (MWT)
  - Positive airway pressure titration studies
- Sleep Apnea Treatment
  - Automatic positive airway pressure (APAP) therapy
  - Continuous positive airway pressure (CPAP) therapy
  - Bilevel or variable positive airway pressure (BPAP) therapy
  - All supplies related to these devices
  - Oral appliance therapy
  - Hypoglossal nerve stimulation therapy

Who is in These Programs?

Below are general guidelines to help identify the members that are a part of our Utilization Management programs. Always verify authorization requirements and member benefits on iLinkBlue, prior to rendering services.

- Fully insured members are a part of all programs. Fully insured members can be identified by the words "Fully Insured" on the member ID card.
- Self-funded members (ASO plans) have an option to be in these programs, with the exception of the Genetic Testing program. All Self-funded (ASO plan) members are in the Genetic Testing program except FEP members. Self-funded member ID cards will include the group name but will NOT include the words "Fully Insured."
- Small Business Funded (SBF) members are a part of all programs. SBF members have "SBF" in the group number in the Group/Subgroup section of their member ID card.
- Office of Group Benefits (OGB) members are a part of all programs, except the Sleep Management Program.

Guidelines for Requesting and Changing a Carelon Authorization (Post Service) for a Louisiana Blue Member

- Providers have two business days post service to get the initial authorization for all program codes **except** Cardiac PCI and MSK procedures without having to go through the post claim clinical appropriateness (PCCA) process. This is Carelon's normal process for all programs.
- MSK Program: Carelon allows seven days post service (retro) for the provider to call and update the original request for MSK program services without having to go through the PCCA process.
- Cardiac PCI Cases: The provider has 10 business days post service to contact Carelon for the cardiac intervention without having to go through the PCCA process. When contacted for an authorization within 10 business days of the service being performed, Carelon will treat the PCI request as a "prospective" case.

Post Claim Clinical Appropriateness Review

If your claim denies advising you to contact Carelon for a medical necessity review, you must submit a new authorization request for the service code(s) that were rejected and require Carelon review.

Post claim clinical appropriateness (PCCA) is what Carelon calls its retro review process. The PCCA process would take place after the 2-day window has passed for those services that do not have a 10-day (Cardiac PCI) or 7-day (MSK) retro review window.

Note: The PCCA review does not apply to Office of Group Benefits policies as well as HMO-HMO policies.

Reconsideration of a Carelon Authorization Request Denied as Not Medically Necessary

- The provider acting on behalf of the member may verbally request a reconsideration via peer to peer by calling Carelon at 1-866-455-8416. A peer to peer with Carelon can be requested at any time, but for reconsideration, the peer to peer must be performed within 10 calendar days of the denial. If the reconsideration continues to uphold the original decision, the member, or the provider acting on behalf of the member, may appeal as described below.
- To initiate the medical appeal process with Louisiana Blue, the member, their authorized representative or the provider authorized to act on the member's behalf must submit a written request to appeal within 180 days following the member's receipt of an initial adverse benefit determination. Medical appeals should be sent to Louisiana Blue at the address found on our Quick Reference Guide at the front of this manual. For more on the Louisiana Blue medical appeals process, please see the Claims Resolutions section of this manual.

DRUG AUTHORIZATIONS

Authorization Requirements

As part of our Drug Utilization Management program, prior authorization is required for certain prescription drugs. Providers may access this list of targeted medications under the Pharmacy section of our Provider page (www.lablue.com/providers). For details on how to request a prior authorization, please see the Authorizations information in the Quick Reference Guide at the front of this manual.

Appeals for drugs denied for medical necessity or experimental/investigational are handled by Express Scripts or Louisiana Blue, based on the member's benefit plan.

Pharmacy Benefit Drugs

Louisiana Blue is contracted with Express Scripts, a pharmacy benefit manager, to perform prior authorizations for pharmacy benefit drugs. Ordering physicians are required to contact Express Scripts to complete authorizations for pharmacy benefit drugs for members of our Preferred Care PPO and HMO Louisiana networks.

Medical Drugs

Louisiana Blue is contracted with Express Scripts, a pharmacy benefit manager, to perform prior authorizations for targeted medical benefit drugs. Ordering physicians are required to contact Express Scripts to complete authorizations for targeted medical benefit drugs for members of our Preferred Care PPO and HMO Louisiana networks.

Prior authorization for non-targeted medications is handled by Louisiana Blue. Please do not contact Express Scripts for these medications.

Please refer to the Reporting National Drug Code (NDC) on Claims guidelines in the Billing and Reimbursement section of this manual for full billing and claims details.

For more information on covered drugs, go to the Pharmacy section of our Provider page.

Step Therapy Program

Step Therapy requires the member to try one or more Step 1 drugs, within select drug classes, prior to trying a more costly Step 2 drug. A benefit of this program is to lower out-of-pocket costs, ultimately decreasing the member's likelihood to stop taking medications due to the cost.

Step 1 – The member first tries one or more Step 1 drugs to treat a medical condition before Louisiana Blue/HMO Louisiana will cover* a Step 2 drug for that condition.

Step 2 – If Step 1 drugs are not clinically appropriate or have been tried and do not work for the member, then Louisiana Blue/HMO Louisiana will cover* a Step 2 drug for that condition.

* Coverage determination is subject to the member's eligibility and benefits. Please always verify member benefits prior to rendering services.

The following drug categories are examples of prescription drugs that are included in the Step Therapy program:

• Acne Treatment Medications	• Oral Diabetes Medications
• Blood Pressure Medications	• Pain and Inflammation Medications
• Bone Medications	• Respiratory/Allergy Medications
• Cholesterol Medications	• Sleep Medications
• Depression Medications	• Stomach Acid Medications
• Frequent Urination Medications	• Triptan Migraine Medications
• Long-Acting Pain Medications	

For information on drug authorizations, visit the Pharmacy section of our Provider page. When a provider writes a prescription for a Step 2 drug within the classes listed above for a member with Step Therapy, the prescription will be denied at the point of sale at the pharmacy if the member has not already tried one or more Step 1 drugs. The pharmacy will inform the member and then contact the provider and advise of the member's Step Therapy benefits. If the provider determines Step 1 drugs aren't appropriate for the member, then the provider can complete the Drug Prior Authorization Form found on our Provider page for an authorization and, if approved, the provider can prescribe a Step 2 drug. If the provider's request does not meet the necessary criteria to start a Step 2 drug without first trying one or more Step 1 drugs, or if the provider or member insists on the Step 2 drug, then the member is responsible for the full cost of the drug.

For information on specific drugs under the program, visit the Pharmacy section of our Provider page.

BEHAVIORAL HEALTH AUTHORIZATIONS

Louisiana Blue manages behavioral health services for our members for authorizations, utilization management, case management and applied behavioral analysis (ABA) case management.

Requests for behavioral health authorization should be submitted through the Louisiana Blue Authorizations application, available on iLinkBlue, under the "Authorizations" menu option.

Behavioral Health Medical Necessity Appeals

Appeals for behavioral health services denied for medical necessity should be sent to Louisiana Blue at the address found on our Quick Reference Guide. For more on the Louisiana Blue medical appeals process, please see the Claims Resolutions section of this manual.

MEDICAL RECORDS

Providers should maintain current, organized, well-documented medical records to facilitate communication, coordination and continuity of care. Records should document all care provided to members.

We perform office reviews and ambulatory medical record reviews (AMRRs) as a commitment to quality improvement. AMRR and site reviews may be conducted for any provider in the following circumstances:

- When requested by one of the medical directors based on quality indicator or provider corrective action processes; or
- At the discretion of the Health and Quality Management staff.

The purpose of the review will be to:

- Objectively monitor and evaluate the structural and operational aspects of the office site; and
- Conduct an overview discussion and assessment regarding the adequacy of medical record practices.

Results from the record keeping review will be used to initiate actions to improve practice management or medical record documentation.

Cloned or Template Generated Documentation

Medical record documentation must be specific to the patient's situation at the time of the service. Each patient will have a unique set of problems, symptoms and treatments, so the expectation is that documentation would not look exactly the same across patients. The expectation would also be that medical record entries for a patient would not be worded exactly alike or similar to previous entries. Please be cautious when using templates to generate the medical record to ensure that what is documented in the medical record actually occurred for that patient.

ADULT AND PEDIATRIC AMBULATORY MEDICAL REVIEW DEFINITION OF GUIDELINES

Pediatric:	Any child between infancy and puberty
Adult:	A fully grown and mature person
Time Frame:	Review all entries for the two years preceding the last visit

Part I – Demographic Guidelines

1. All pages with entries in the record contain patient identification.

   Definition: Name, Social Security number or other unique patient identifier is on all pages with entries.

2. Personal biographical data

   Definition: The personal biographical data should include: address, employer, home and work telephone numbers and marital status. If the patient has no phone, the record should state "no phone." For pediatric cases, the employer of at least one parent, as well as the home and work phone numbers of at least one parent should be included.

Part II – Documentation Guidelines

1. Each entry in the record contains the author's name or initials.

   Definition: An entry means documentation in the progress notes. This may include medication renewals and telephone orders. Author identification may be handwritten signature, an initialed stamped signature or unique electronic identifier. Each entry has the author's name or initials. Documentation entered by someone other than the practitioner must be counter-signed or counter-initialed. All signatures should be completed prior to billing for the service.

2. Each entry is dated.

   Definition: This includes progress notes, problem list, medication list, assessment form, etc.

3. Each entry is legible.

4. Smoking habits and history of alcohol or substance usage are noted.

   Definition: For patients 14 years and older, smoking habits, ethyl alcohol (ETOH) use and substance use are noted in the history and physical progress notes. Counseling in reference to avoiding tobacco use, underage drinking and illicit drug use including, but not limited to, avoiding ETOH/drug use while swimming, boating, etc., is noted. For patients seen three or more times, query a substance use history.

5. A history and physical is noted for each visit.

   Definition: The reason for the visit or chief complaint is noted. There is appropriate subjective and objective information noted pertinent to the patient's presenting complaints to include but not limited to height, weight and blood pressure.

6. Labs and other studies are ordered as appropriate.

7. Each encounter has follow-up care, calls or visits noted.

   Definition: Each physician encounter has a notation regarding follow-up care, calls or visits, unless there is a notation that previous problem has been resolved. The specific time of return is noted in days, weeks, months or PRN (as needed).

8. At each encounter, problems from previous visits are addressed, if applicable.
9. Review of underutilization and overutilization of consultants.

   Definition: There is evidence of continuity and coordination of care between primary and specialty physician. There is evidence of appropriate use of consults.

10. Consultant's report or note from consultant is received, if applicable.

    Definition: If there was consult, there is a report of the consult in the record.

11. Consultation, lab and imaging reports filed in the chart are initialed and signify review.
12. Immunization

    Definition: There should be an up-to-date immunization record for children. For adults, an appropriate history should be made.

13. Preventive Healthcare

    Definition: Documentation that preventive screenings and services are offered in accordance with current Preventive Medicine Guidelines. See our Provider page.

Guidelines – Critical Elements

1. The record contains an updated, completed problem list or summary of health maintenance exams.

   Definition: An updated, completed problem list summarizing significant illnesses, medical conditions, past surgical procedures or chronic health problems that is updated as new problems are encountered, as evidenced in the progress notes. The problem list can be in a separate section or can be listed as a problem in the progress notes. If no past or current illnesses, conditions or past surgical procedures, there is a statement that no current or past problems are noted. In this case, there is a summary of health maintenance exams such as well woman exam, well child exam, routine checkup or complete physical exam.

2. Allergies and adverse reactions to medications are prominently displayed.

   Definition: The patient's medication allergies and adverse reactions must be conspicuously listed in the ambulatory medical record or on the front or inside cover of the medical record folder. If allergies to medications are absent, "No Known Allergies" (NKA) or "NA" or "None" is conspicuously documented in the ambulatory medical record or on the front or inside cover of the medical record folder. Conspicuously means in an obvious location, e.g., upper corner or left or right side of the progress note. You should not have to search for this information.

3. There is a past medical history in the record.

   Definition: For patients seen three or more times, a past history should be easily identified. "Easily identified," means it should be in one central area, not scattered throughout the chart. An inpatient history and physical taken by the provider is acceptable. For children and adolescents under the age of 18, past medical history will relate to prenatal care, operations, childhood illnesses and birth to include, but not limited to: evidence of hemoglobinopathy screening, phenylalanine level, T4 and/or TSH and ocular prophylaxis. For patients seen fewer than three times, there is a past history noted for the current condition. For example, when there is a visit for hypertension, a family history, a patient history and a progress note for hypertension will be documented. For females more than 18 years of age, there must be an obstetrics and gynecological history. If there has been no break in the patient/physician relationship and there is a past history in the chart that was completed while the patient had another form of insurance, the guideline is satisfied.

4. Working diagnoses are consistent with findings.
5. Treatment plans are consistent with diagnoses.
6. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic problem.

Clinical Criteria

Our Medical Management team may use InterQual criteria or medical policy criteria when reviewing authorization requests.

InterQual criteria are integrated into the Louisiana Blue Authorizations application that is available through iLinkBlue (www.lablue.com/ilinkblue). Within this application, providers can access the criteria within the member's authorization.

Louisiana Blue medical policy criteria are available through iLinkBlue (www.lablue.com/ilinkblue) under the Resources section.

If your authorization was performed by one of our vendors, you can access their criteria by visiting their website:

- Louisiana Blue has several utilization management programs administered by Carelon. Carelon clinical appropriateness guidelines are available online at www.guidelines.carelonmedicalbenefitsmanagement.com.

MEDICAL POLICY

Medical Policy Review

Louisiana Blue develops medical policies to provide consistent determination of the medical appropriateness of treatments, procedures, devices, drugs and biological products.

Services with an applicable medical policy and services that require prior authorization are NOT the same.

There are many services with an applicable medical policy that do not require a prior authorization. There are also many services that require a prior authorization, but do not have an applicable medical policy.

Services with an applicable medical policy can be reviewed prior to the service being rendered, whether it requires a prior authorization or not. This is done by the provider requesting a predetermination prior to the service(s) being rendered. To initiate a request, access the Louisiana Blue Authorizations application through iLinkBlue (www.lablue.com/ilinkblue) under the "Authorizations" menu option.

Notes:

- Services with an applicable medical policy will be reviewed, either pre-service by the provider requesting a predetermination or post service when the claim is submitted. All services with an applicable medical policy will be reviewed prior to claims payment. Services that are not medically necessary or investigational will not be reimbursed, and these services are not billable to the member.
- Services with an applicable medical policy rendered during an observation stay will be reviewed prior to claims payment.

Medical Policy Inquiry

Provider inquiries related to medical policy will be considered upon written request by a member's provider. All current medical policy coverage guidelines are available on iLinkBlue.

Requests for consideration must be accompanied by the supporting clinical information that is addressed within the medical policy.

Supporting Data Will Be Assessed Against the Following Criteria:

- Have final approval from the appropriate government regulatory body;
- Have the scientific evidence that permits conclusions concerning the effect of the technology on health outcomes; or
- Improve the net health outcome; or
- Be as beneficial as any established alternative; or
- Show improvement outside the investigational settings.

Procedure

Providers that contact us to address coverage eligibility or investigational status of a treatment, procedure, device, drug or biological product addressed in a Louisiana Blue medical policy will be directed to submit:

- A written request that includes the nature of their inquiry; and
- Pertinent, peer reviewed, scientific, evidence-based outcomes specific to the coverage eligibility guidelines or investigational status of the treatment, procedure, device, drug or biological product addressed within the medical policy.

Additionally:

- Written requests must include a return address or fax contact number.
- Supporting data will be reviewed by the medical director of the Medical Policy Department and/or appropriate Plan medical directors and consultants.
- Upon determination of the review outcome, written notification will be directed to the requesting provider within 60 days of receipt of request.

Observation Stay Medical Policy Reviews

The payment of observation services is limited to a maximum of 48 hours of observation. The 48-hour count commences when outpatient services begin. This is when the member arrives at the facility for treatment, not when the observation status begins.

Observation stays do not require prior authorization. However, Louisiana Blue will review services provided during an observation stay against applicable medical policies prior to claims payment. Services that are not medically necessary or investigational will not be reimbursed, and these services are not billable to the member.

Providers are encouraged to request a predetermination review of medical policy services that will be performed during an observation stay prior to the service(s) being rendered. To initiate a request, access the Louisiana Blue Authorizations application through iLinkBlue (www.lablue.com/ilinkblue) under the "Authorizations" menu option.

Carelon reviews a subset of Louisiana Blue medical policies, but not in the observation setting. If Carelon reviews and denies a service related to medical policy in a setting other than observation, Louisiana Blue will not reimburse the same service even though performed in the observation setting. If your original plan of care includes services with applicable medical policy and criteria that are now planned for the observation setting, contact Louisiana Blue directly.

If you would like to review specific medical policy coverage guidelines, access our medical policy index on iLinkBlue (www.lablue.com/ilinkblue) under the "Authorizations" section. Policies are listed in alphabetical order or you may search by keyword, procedure code, policy name or policy number.

QUALITY BLUE PROGRAM

Quality Blue is an innovative healthcare quality improvement program. Louisiana Blue has taken a leadership role in developing programs that reward providers for quality improvements that get better health results for patients while making healthcare more affordable.

The Quality Blue program promotes and enhances preventive wellness and disease management. In addition, Quality Blue encourages value-based (as opposed to volume-based) practice methods by equipping providers with a performance-based payment structure. Providers may be eligible to receive financial incentives for successfully achieving quality and total cost of care goals as outlined in their Quality Blue Program Participation Agreements. Each attribute of Quality Blue was designed to successfully facilitate the necessary transformation to improve the health and lives of Louisianians.

QUALITY MANAGEMENT (QM) PROGRAM

The goal of the QM Program is to continuously maximize and improve the healthcare services delivered to members.

The scope of the QM Program is a commitment to the continued development of ongoing systems to monitor and enhance healthcare services delivered to members in all settings. Activities reviewed, supported, performed and/or monitored by the QM Program include, but not limited to, the following:

- Accreditation
- Affordable Care Act requirements
- Committee functions
- Quality of care issues
- Grievance resolution
- Member satisfaction
- Credentialing and recredentialing
- Performance measures: including Healthcare Effectiveness Data and Information Set (HEDIS), Quality Star Ratings (QSR)
- Utilization and management of services
- Health management and wellness activities to include care management
- Clinical, non-clinical and safety-related quality improvement activities
- Preventive care guidelines
- Medical management process audits
- Oversight of delegated functions including but not limited to pharmacy and radiology services

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

HEDIS is a set of healthcare performance measures developed by the National Committee for Quality Assurance (NCQA) and used by the U.S. Centers for Medicare & Medicaid Services (CMS) for monitoring health plans and providers to evaluate their performance in terms of clinical quality and customer service. Louisiana Blue participates in annual HEDIS reporting as a requirement to maintain our health plan accreditation and a subset of HEDIS measures is reported to CMS as a condition of certification and participation in the marketplace for Quality Rating System (QRS).

- HEDIS is a common set of comparable measurements that relates to current national clinical priorities. Measurement results are used for implementing interventions to close gaps in care and quality improvement projects/programs.
- QRS is a subset of HEDIS measures plus one Pharmacy Quality Alliance measure that is used for our Stars ratings.
- HEDIS data is collected in three different ways:
  - Administrative data (claims only)
  - Hybrid data (claims database and medical record review)
  - Survey data (member and provider surveys)

Provider's Role in HEDIS

- Provide appropriate care to meet the criteria and timeframes of each measure.
- Document care provided in the member's medical record.
- Submit accurate coding for claims.
- Provide medical records during the HEDIS process to help us validate the quality of care provided to our members.
  - Medical record requests are faxed to providers and include a member list that indicates their assigned measures and the minimum necessary information needed.
  - HEDIS data is collected and reviewed from January to May.
  - Under the HIPAA Privacy Rule, data collection for HEDIS is permitted, and release of this information requires no special patient consent or authorization.
  - Receiving all requested medical records (ideally in 5–7 business days) ensures that our results are an accurate reflection of care provided.
  - Provider agreements allow for the release of medical information to Louisiana Blue or its designee at no cost for quality improvement efforts.

POPULATION HEALTH

The U.S. Centers for Disease Control & Prevention (CDC) views population health as an interdisciplinary customizable approach "that brings significant health concerns into focus and addresses ways that resources can be allocated to overcome the problems that drive poor health conditions in the population." Louisiana Blue operates within this framework to establish programs that help to achieve positive health outcomes for members.

Key Components of the Population Health Improvement Model Include

- Population identification strategies and processes.
- Comprehensive needs assessments that assess physical, psychological, economic and environmental needs.
- Proactive health promotion programs that increase awareness of the health risks associated with certain personal behaviors and lifestyles.
- Patient-centric health management goals and education, which may include primary prevention, behavior modification programs and support for concordance between the patient and the primary care provider.
- Self-management interventions aimed at influencing the targeted population to make behavioral changes.
- Routine reporting and feedback loops, which may include communications with patient, physicians, Health Plan and ancillary providers.
- Evaluation of clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall population health.

The Population Health Improvement Model

- Encourages patients to have a provider relationship where they receive ongoing primary care in addition to specialty care.
- Complements the physician/practitioner and patient relationship and plan of care across all stages, including wellness, prevention, chronic, acute and end-of-life care.
- Assists unpaid caregivers, such as family and friends, by providing relevant information and care coordination.
- Offers physicians additional resources to address gaps in patient healthcare literacy, knowledge of the healthcare system and timeliness of treatment.
- Assists physicians in collecting, coordinating and analyzing patient-specific information and data from multiple members of the healthcare team including the patients themselves.
- Assists physicians in analyzing data across entire patient populations.
- Addresses cultural sensitivities and preferences of individuals from disparate backgrounds.
- Promotes complementary care settings and techniques such as group visits, remote patient monitoring, telemedicine, telehealth and behavior modification and motivation techniques for appropriate patient populations.

CARE MANAGEMENT PROGRAMS

Our clinical team stands with you, ready to support your patients on their journey to optimal health. We have multidisciplinary teams of clinical professionals, including doctors, nurses, pharmacists, dietitians and behavioral health case managers. We also offer many long-standing, results-driven programs to support your patient relationships and help our mutual customers — your patients, our members — achieve their health and wellness goals.

These programs include:

- Case Management
- Complex Case Management
- Disease Management
- Rare Condition Management in partnership with Accordant, an independent health management company
- Preventive and Wellness Services
- Behavioral Health Case Management
- Utilization Review
- Pharmacy

There is no out-of-pocket cost to a patient to work with a Louisiana Blue health coach. For details on how to make referrals to a program or on how patients enrolled in a Louisiana Blue Care Management Program can opt out, please see the Care Management information in the Quick Reference Guide at the front of this manual.

Case Management

Case Management programs encourage collaborative relationships among a member's healthcare providers, and help members and their families maximize efficient utilization of available healthcare resources. These programs include:

- **Discharge Outreach**: Nurses engage select patients at high risk of readmission within 48-72 hours of discharge to assess their needs, make sure they are taking any medication as directed, coordinate care and help them lower their risks of complications and/or readmissions.
- **Emergency Room Outreach**: Our health coaches work with your patients who go to the emergency often to connect them with primary care providers who can handle most of their health needs when they are sick or injured. We want to help your patients access care in the right setting outside of office visits with you and save on their out-of-pocket cost so they get the most value out of their health plan benefits.
- **High Utilizers/High Cost**: Louisiana Blue encourages all of its members to have a primary care provider who handles most of their health needs when they are sick or injured. We particularly emphasize this for patients who have a lot of healthcare needs. The overall goal is to help these patients with care coordination and lower their risks of admissions and readmissions.

- **Oncology Management**: We support patients who are in active cancer treatment to help them manage treatment side effects and symptoms, assess access to care and coordinate services. We also offer education on Louisiana Physician Orders for Scope of Treatment (LaPOST) and other life care-planning legal documents.
- **Tobacco Cessation**: Nurses help patients who are trying to quit smoking or using tobacco to work through the stages of this change, set and meet goals and stick to quitting. Nurses also connect these patients with primary care doctors, community resources and other support services.
- **Transplant Care Management**: We work with patients who have had organ/tissue transplants to educate them on risks, promote safety, manage comorbidities and offer support throughout their care experience. This program helps improve transplant outcomes, lower the risk for hospitalizations and readmissions and lower overall costs associated with the transplant.

Complex Case Management

Louisiana Blue's Complex Case Management (CCM) Program is designed to help members with complex diseases to regain optimal health or improved functional capacity. Conditions and complex diseases that often benefit from the CCM Program include:

- Hypertension
- Congestive Heart Failure (CHF)
- Atrial Fibrillation
- Coronary Artery Disease
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)

These conditions result in increased acute inpatient hospitalizations and emergency department utilization, which drive healthcare costs, making them complex conditions to manage. The program provides coordination of care and ensures applicable resources are delivered in the most cost-efficient setting for members who require extensive or ongoing services. Developed in accordance with the Case Management Society of America's (CMSA) Standards of Practice and evidence-based clinical practice guidelines, CCM services include a comprehensive assessment of the member's health status; determination of available benefits and resources; development and implementation of a care management plan with performance goals, ongoing monitoring and follow-up. Services are provided telephonically and through written educational communication, with an overall goal of improving the member's ability to self-manage his or her condition through increasing care coordination and interaction with the member's PCP and reducing unnecessary acute inpatient admissions and emergency department utilization.

Objectives of Louisiana Blue's CCM Program Include:

1. To identify and provide care coordination to members with complex diseases or conditions who might benefit from care management services.

2. To facilitate processes to actively assist members and providers with the management of those diseases and to promote self-management of these health conditions.
3. To facilitate access to medical services, preventive health services, behavioral health services and social services, in addition to other resources.
4. To encourage involvement of members and caregivers in the care process.
5. To ensure appropriate utilization of services and benefits.
6. To promote effective and ongoing health education and disease prevention activities.
7. To assist the member to regain optimal health or improved functional capability.
8. To ensure case management activities take into consideration the patient's health status, history, medications, condition-specific issues, activities of daily living, cognitive and mental health status, life-planning activities and cultural and physical preferences and limitations.
9. To assist in the identification of barriers and how to overcome them, progress assessment, prioritization of goals, follow-up and communication of self-management plans, as well as involvement of caregivers and referrals to resources.

CCM Program Referral Process:

- Each referral is reviewed for enrollment in CCM based on available information and telephonic member assessment.
- Participation in this program is voluntary and at no cost for all eligible Louisiana Blue members.
- If a provider would like to refer a member or request additional information regarding eligibility in the CCM Program, please call toll-free 1-800-317-2299 (TTY 711).

Disease Management

Louisiana Blue health coaches are here to help your patients stay on top of their long-term health needs. These programs aim to improve the physical and psychosocial well-being of patients through cost-effective, personalized solutions. We will empower your patients to reach their best health. Disease Management programs are here to support your patients who have any of the following health conditions:

- Asthma
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Coronary Artery Disease/Hypertension
- Diabetes
- End Stage Renal Disease
- Prediabetes/Metabolic Syndrome

Note: Louisiana Blue is constantly assessing the market and may add disease management programs for other conditions as appropriate.

Rare Condition Management

Louisiana Blue offers the My Health, My Way program* in partnership with Accordant, an independent health management company, to support patients who have any of 17 rare conditions with health coaching, follow-up and education.

My Health, My Way supports patients who have any of the following 17 rare chronic conditions:

- Amyotrophic Lateral Sclerosis (ALS)
- Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP)
- Crohn's Disease
- Ulcerative Colitis
- Cystic Fibrosis (CF)
- Dermatomyositis
- Gaucher Disease
- Hemophilia
- Multiple Sclerosis (MS)
- Myasthenia Gravis (MG)
- Parkinson's Disease (PD)
- Polymyositis
- Rheumatoid Arthritis (RA)
- Scleroderma
- Epilepsy (Seizures)
- Sickle Cell Disease
- Systemic Lupus Erythematosus (SLE or Lupus)

*To see if your patient is eligible for this program, please contact the Care Management Team at the number found in our Quick Reference Guide in the front of this manual.

MATERNITY MANAGEMENT PROGRAM - HEALTHY BLUE BEGINNINGS

Our maternity management program, Healthy Blue Beginnings, helps promote early and compliant prenatal care and offers case management support when required. If a provider has patients who are pregnant or are thinking of becoming pregnant, they should notify our maternity program staff who will assess the patient for risks and provide lifestyle risk modification coaching and reliable information resources. Locate the Care Management Disease Management (CMDM) Referral Form online at www.lablue.com/providers >Programs >Care Management. Providers should complete and fax it to (225) 298-3184 to have a patient enrolled. Providers may also contact us directly or have the patient call the number on their member ID card and ask to speak with a nurse. Once a patient is enrolled, providers will receive the following:

- Written or telephonic notification of the patient's enrollment along with the nurse's contact information.
- Notification when the Louisiana Blue nurse identifies the patient may be in need of healthcare services via a care coordination nurse call.
- Access to claims-based Louisiana Blue health records with up to three years of claims history (through iLinkBlue).
- Referral by Louisiana Blue nurses for members who do not have an established physician relationship and self-refer to the program.

A successful maternity management program is dependent on early identification of patients planning to become pregnant, or who have recently identified they are pregnant. The provider plays a key role in the delivery of the program, and this program is intended only to complement the medical care received from providers.