AmeriHealth Caritas Louisiana
Provider Advisory Council (PAC) Meeting Minutes
Wednesday September 25, 2024 1:00 p.m.

Attendees:

Present from AmeriHealth Caritas Louisiana:	**Guest Attendees:**
Kyle Viator, Market President AC Louisiana, Administration	Reagon Zufelt with New Day Recovery
Thomas Godfrey, Director Plan Operations & Administration, Administration	Christina Clements with New Day Recovery
Kelli Clement, Director Provider Network Ops, Provider Operations and Administration	Carolyn McDonald with Allegiance Health Management
Rhonda Baird – Director Quality Management, Quality Management	Greg Ivey with Pediatric Center SW LA
Gwen Matthews, Director Provider Network Management, Provider Network Mgmt.	Deirdre Davis with LA Women's Healthcare
Bridgette Robertson, Manager Provider Network Operations, Provider Operations & Admin	Ginger Ezell with Allegiance Health Management
Glynda Hurm, Manager Provider Network Management, Provider Network Mgmt.	Skyler Stewart with New Day Recovery
Nancy Thibodeaux, Provider Network Analyst, Provider Operations and Administration	Sherice Forte with Verity Health
Wanakee Eames, Health Equity & Quality Analyst, Quality Health Equity	Karen Baird with New Day Recovery
Ahmed Olayanju, Manager Provider Network Management, Provider Network Mgmt.	Kim Boudreaux with Thibodaux Regional Health System
Jana Blaylock, Manager Quality Management, Quality Management	Katina Celestine
Penny Foster, Manager Regulatory Affairs, Compliance Medicaid	Robert Hanser
Lakesha Dickerson, Manager UM Review, Utilization Management	Shneese Player with Metropolitan Circles
Kursten Munson, Manager UM Review, Utilization Management	Tubassam Abbasi with Allegiance Health Management
Latasha Delmore, Executive Assistant II, Administration	Bridget Duplechain with Savoy Medical
Gloria Winchester, Housing Program Manager, Care Coordination Case Management	Kristi Cadarette with Woman's Hospital
	Angie Weems with SMRMC
	Jacquline Nwufoh
	Robin Searcy with CASSE
	Frank Folino with DCSNO
	Lee Reilly with Access Health LA
	Victoria Elliott with Pinnacle Family

AGENDA ITEM	DISCUSSION	CONCLUSION / RESULTS	ACTION STEPS / PERSON RESPONSIBLE	DATE DUE
I. Call to Order	**Bridgette Robertson, Manager Network Operations-Operations,** welcomed everyone to the PAC Meeting of September 25, 2024 (virtually via Zoom) at 1:00 p.m. and went over housekeeping for the meeting.			
II. Agenda	**Bridgette Robertson, Manager Network Operations-Operations,** presented the meeting agenda.			
III. Introduction	**Thomas Godfrey, Director Plan Operations & Administration, Administration,** introduced himself and all present in the meeting room and asked attendees to introduce themselves.			
IV. Provider Network Management	**Gwen Matthews, Director Provider Network Management, Provider Network Mgmt.** presented the following information: • Training Opportunities – Top Denials and Tips on How to Resolve Them		.	

	• NaviNet:
	  o Training Videos for:
	    ▪ Authorization Inquiry Process
	    ▪ Authorization Submission Process
	    ▪ Care Gap Response Forms
	    ▪ Condition Optimization Program
	
	• Account Executives can assist navigating NaviNet (slide with AEs names, phone numbers, and their regions presented as well)
	• Value Based Programs:
	  o PerformPlus is a suite of value-based incentive programs designed to improve quality, efficiency, patient satisfaction, and provider experience
	  o It’s designed to:
	    ▪ Improve the integration of physical and behavioral health services
	    ▪ Provide physicians with the tools they need for success
	    ▪ Improve the member experience
	    ▪ Avoid waste and duplication of care
	    ▪ Bring cost trends in line with or below inflation
	    ▪ Allow customizations to meet the unique needs of our health care delivery partners
	
	Discussion:
	None.
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V. Utilization Management	**Lakesha Dickerson, Manager UM Review, Utilization Management,** presented the following information:
	
	• UM Process:
	  o To initiate prior authorization, providers can call, fax or submit a request through NaviNet
	  o Patient symptoms, history, and prior treatment info should be sent with the request
	  o Ordering provider is responsible for obtaining a prior authorization for the service requested
	  o ER, Observation care and inpatient imaging procedures do not require prior authorization
	  o PA Lookup Tool on our website allows provider to lookup a code to see if a code requires prior authorization (slide showing PA Lookup Tool on our website was presented as well)
	  o NaviNet requests must include the following:
	    ▪ Member’s name
	    ▪ Member’s DOB
	    ▪ Member ID (Plan or Medicaid)
	    ▪ Provider contact information
	  o Failure to include these items could result in a delay in processing the request
	• Turnaround Times:
	  o Concurrent Review– 1 calendar day
	  o Prior Authorization Review – 14 calendar days
	  o Prior Authorization Urgent Review – 3 calendar days
	  o Retrospective Review – 30 calendar days
	• Services that do not Require Prior Authorization:
	  o Continuity of Care for 1st 30 days after member enrolls
	  o Dialysis at freestanding or hospital-based OP dialysis facilities (including supplies)
	  o DME under $750 (in network) **except:**
	    ▪ Custom orthotics and prosthetics
	    ▪ Diapers/pull-ups (ages 4-20) for those who qualify (Quantities over 200 per month for either or both or Brand-specific diapers
	    ▪ Rentals
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	▪ Wheelchair parts o EPSDT screenings (in and out of network) o ER (in and out of network) o Family planning (in and out of network) o Low-level x-rays, electrocardiograms (in network) o Observation – 48 hours (in network) o Post-stabilization (in and out of network) o Routine vision (in network) o Sterilization (in network) o Urgent care (in and out of network) o Women's health care/OB/GYN (in network) Discussion: ➢ B. Robertson: Does anyone use the Prior Authorization Lookup Tool to determine if services require a prior authorization or not? ➢ No response. ➢ B. Robertson: If the provider does not submit the required information for the authorization or if something is missing like the date of birth is there an outreach to the provider to let them know something's missing or how would they know that something's missing? ➢ L. Dickerson: Yes, our intake team or our nurses will reach out to the provider and let them know the HIPAA requirements are not met because we need those identifiers to verify the member's ID and HIPAA checks as well.			
VI. Behavioral Health Utilization Management	**Kursten Munson, Manager UM Review, Utilization Managemen**t presented the following information: • Prior authorization is not required for below services, but notification is required to coordinate care for members: o Alcohol/SUD acute or subacute detox for first 5 days o Crisis intervention services (initial) o Mobile crisis response (MCR) o Behavioral health crisis care (BHCC) • Services that do require prior authorization: o Medical psychoanalysis o Electroconvulsive therapy (ECT) o Applied behavior analysis (ABA) o Psychological, neuropsychological, or developmental testing o Outpatient addiction services o Mental health rehab for child, adolescent, and adults o Community brief crisis support (CBCS) o Individual placement and support (IPS) o Personal care services (PCS) o Peer support services (PSS) o Mental health intensive outpatient program (MH IOP) o Inpatient/residential levels of care			

- How to request a prior or continued stay authorization:
  - Fax or Provider Portal only:
    - BH outpatient
    - BH psychological and neuropsychological testing
    - Child, adolescent and adult MHRS
    - SUD IOP
    - Applied Behavior Analysis
  - Fax, Provider Portal, or telephonic review:
    - Crisis intervention follow up
    - SUD residential or halfway house services
    - Psychiatric inpatient hospitalization
  - Telephonic review only:
    - ECT
  - Provider portal only:
    - MH IOP
  - Faxed form only for all initial request and telephonic review for continued stay requests
- ACLA Decision and Notification Timeframe:
  - CPST and PRS – 5 calendar days
  - BH Crisis Services – 1 calendar day
  - PRTF – 48 hours
  - Non-Urgent – 2 business days
- Medical Denial Reconsideration and Appeals:
  - Provider has 5 business days from notification to set up a Peer to Peer reconsideration and they are addressed within 1 business day after receipt
  - Provider complaint has a 30 day window from adverse determination
  - A member or provider on behalf of the member can appeal an adverse determination within 60 days of the denial notice

Discussion:

- K. Clement: Kursten, would you explain the difference between a prior authorization and just a notification and is the process any different?
- K. Munson: For notification we do require that the service was provided to the member, but we do not perform a medically necessary review. It’s an automatic approval with cert number but cert number is not needed to bill for that service. Where if it requires a prior authorization, we are performing a medically necessary review to ensure utilizing of any of our criteria clinical coverage policies and that the member meets medical necessity of the service before the service is provided.

VII. Culturally and Linguistically Appropriate Services (CLAS)	**Wanakee Eames, Health Equity & Quality Analyst, Quality Health Equity,** presented the following information:
	
	• Importance of Collecting Race, ethnicity, language (REL) data:
	    o Assists members with choosing a provider that meets their cultural preferences
	    o It gives us an idea of providers that are available who meet the member's linguistic needs and encourages trusting relationships between members and their provider, and they usually feel more comfortable when their cultural needs are being understood
	    o It also helps us in identify and tracking health disparities
	    o It promotes equitable care because having a diverse provider network ensures that we're able to provide the needed care for our diverse population which can greatly increase healthy outcomes
	    o It gives a sense of autonomy for members to be able to choose a provider who meets their cultural preferences, and it gives a sense of importance, and members are more likely to engage if they feel like they can relate to that provider
	
	Discussion:
	None.			

VIII. Quality Management	**Rhonda Baird, Director Quality Management, Quality Management**, presented the following information:
	
	• End of Year Gap Closures:
	    o 4th quarter push by getting members in for services and getting members seen by providers that may have not been seen by a provider this year and closing gaps that will impact quality for providers and the Plan
	    o We will be reaching out to many providers to offer support, share care gap lists, and we would be happy to accommodate any providers that would need additional support around member outreach calls
	    o NaviNet resources that providers have access to as far as Care Gap Reports, ADT Alerts, and Provider Performance Rollup Reports but if any providers need us to supply Care Gap list we are certainly able to do that
	    o A lot of these measures are tied to incentives so that effects providers value base contracts as well as any enhancement programs that we offer
	• CPT CAT II Code Provider Incentives:
	    o This gives us the outcome of blood pressure readings, A1c readings as well as diabetes retinal eye exams so we encourage providers to use that and there is an incentive tied to that and providers can use the blood pressure CPT CAT II codes and the A1c CAT II codes once every 90 days and the eye can be used once per year
	• Cervical Cancer Screening Provider Incentive for Q4:
	    o If providers need us to work with them on non-compliant list or member outreach calls, we will be doing that on our end but will certainly accommodate any support we can give to help get members in to close gaps and get the services before the year ends.
	• EHR Access and Data Exchanges:
	    o We encourage our providers to allow us EHR access and/or participate in a data exchange with us because it really decreases the administrative burden of provider's office around the numerous medical record requests that come throughout the year
	    o It also improves Quality scores
	    o We will meet with providers to discuss what possibilities are out there for data exchange to			

	eliminate the need for medical record requests because we are able to pick up the details that are often not picked up in claims either because not billed correctly or not using a CAT II code so were not getting the outcomes of those A1cs. Discussion: ➢ K. Viator: How much are the incentives (CAT II)? ➢ R. Baird: They vary...the blood pressures are $5 once every 90 days, the A1c is $10 once every 90 days and the retinal eye is $10 once per year. ➢ K. Viator: Do any of the providers have recommendations or is there anything more that we can offer to make it more likely for your practices to submit these codes as part of your claim submissions? ➢ G. Ezell: I would like to add I know with the software we use there is some AI information that is available as far as what's documented in the note will automatically assign a CPT II code so I guess my recommendation would be for everyone to check with their software to see if there's any kind of technology involved with that. ➢ B Duplechain (Sent in Chat): Our computer system automatically assigns HCPCS codes instead of CPT II codes. ➢ K. Viator: That's very helpful. ➢ K. Viator: There are multiple tests that qualify for the cancer screenings, correct? ➢ R. Baird: Correct, the guidelines for that are included in the provider alert and it's members that are 21-64 years old that had cervical cytology performed within the last 3 years or hr HPV ages 30-62 performed within the last 5 years. ➢ K. Viator: So historically we were able to see them being able to close that gap with more primary care physicians having the ability to do this. ➢ R. Baird: Yes. ➢ J. Blaylock: I wanted to add a quick caveat regarding the billing of the CPT CAT II codes specifically to the hemoglobin A1c results, just a reminder when an A1c test is billed, and the result codes are not sent, that member now becomes compliant for A1c greater than 9 population which is not a positive thing. The rate for A1c greater than 9 is lower rates are better to inverse measure so when a test is billed they automatically fall into that greater than 9 category and if we had EHR access, we can go in and pull the actual result and say it was 7.1 then we could submit that as our non-standard review and it will fall into the correct population of less than 7 or less than 8. ➢ R. Baird: Thank you, Jana. It is the last one of the year for both, so it's going to be the most recent blood pressure that would be used for HEDIS as well as the most recent A1c so any members that have a high A1c or high blood pressure would need to be retested before the end of the year to try to get them into compliance.			

IX. Provider Network Operations	**Kelli Clement, Director Provider Network Ops, Provider Operations and Administration**, presented the following information:
	
	• 275 Attachment Claim Transactions:
	  o ACLA began accepting 275 attachment claim transactions last August of 2023 with Edi submissions to reduce administrative burden which allows providers to attach supporting documentation when submitting claims electronically
	  o The following report codes must be used when submitting an attachment:
	    ▪ Itemized Bill - 03
	    ▪ Medical Records for HAC review – M1			

    - Single Case Agreement (SCA)/LOA - 04
    - Advance Beneficiary Notice (ABN) - 05
    - Consent Form - CK
    - Manufacturer Suggested Retail Price/Invoice - 06
    - Electric Breast Pump Request Form - 07
    - CME Checklist consent forms (Child Medical Eval) - 08
    - EOBs – for 275 attachments should only be used for non-covered or exhausted benefit letter - EB
    - Certification of the Decision to Terminate Pregnancy - CT
    - Ambulance Trip Notes/Run Sheet – AM

Bridgette Robertson, Manager Network Operations-Operations, presented the following information:

- Provider Complaints:
  - A complaint is any expression by any provider indicating dissatisfaction with an ACLA policy, procedure, or any other aspect of administrative functions (excluding requests for reconsideration of a claim or prior authorization denials/reductions)
  - Complaints must be filed in one of the ways listed below:
    - By phone: 1-888-922-0007 from 7 a.m. to 6 pm. Central Time, Monday-Friday
    - By mail: Attn: Provider Complaints, AmeriHealth Caritas Louisiana, P. O. Box 7323, London, KY 40742
    - By email: Network@amerihealthcaritasla.com
    - By online portal in NaviNet
    - Or request an on-site meeting to discuss your complaint with Provider Network Management Account Executive
- Provider Disputes:
  - Two levels of provider disputes post claim services:
    - 1st level dispute which is sometimes called a claim reconsideration is a request for post-service review of claims that have been denied or underpaid
    - If a provider is not satisfied with the 1st level dispute resolution, a 2nd level dispute (sometimes known as a claim appeal) may be filed within 90 days from the date of the 1st level dispute
    - We have a form on our website that is used for 1st and 2nd level disputes and when provider fills out the form they will need to check either 1st level or 2nd level.
    - We make determinations within 30 calendar days of receipt of the claim dispute
    - If the decision is overturned, meaning in favor of the provider, the provider will not receive a decision notice the provider will be notified on the remit that the claim has been recycled for payment
    - If the decision is upheld, we will send the provider a letter and it will explain the reason the dispute was upheld.
    - Disputes may be mailed or submitted via NaviNet
    - If by mail, send to, AmeriHealth Caritas Louisiana, Attn: Provider Disputes, P. O. Box 7323, London, KY 40742
- Independent Review:
  - This is an additional review that can be requested in writing on the LDH required form within 180 days of the transmittal date of the remit or 60 days from the claim submission if no remit is

received or the date of claim recoupment.
    - Can be submitted in writing to AmeriHealth Caritas Louisiana, Attn: Provider Disputes, P. O. Box 7323, London, KY 40742
    - Or can be emailed to: ACLAIndependentReviewRequest@amerihealthcaritas.com
    - Or submitted via NaviNet
    - They will be resolved with 45 days of receipt
- Appeals:
    - Standard appeals from Member and/or Provider on behalf of a Member:
        - We will need member consent if the provider appeals and if it is not received, it will delay processing time
        - 60 calendar days to file from original adverse determination
        - Resolution will be within 30 calendar days from receipt of valid request
        - If no member consent is received within 30 days, the case is dismissed, and a letter is sent to let provider know it has been dismissed
        - Acknowledgement letter sent within 5 business days of a valid appeal
        - Extension may be requested either in writing or oral within 14 calendar days
    - Expedited appeals from Member and/or Provider on behalf of a Member:
        - 60 calendar days from original notice of adverse determination
        - Resolution will be within 72 hours from receipt
        - There are sometimes an expedited appeal is downgraded to a standard appeal and that would be determined by the Medical Director
        - If it is downgraded, the provider will be notified
        - Acknowledgement letter is not sent due to the time frame
        - No extensions
- LDH Provider Services Manual Updates:
    - Pharmacy Benefits Management Services - reimbursement
    - Home Health – prior authorization
    - LT-PCS – covered services, services delivery, forms/documents/links
    - Behavioral Health Services – Evidence Based Practices (DBT, EMDR, Trauma-Focused Cognitive Behavioral Therapy, Triple P, Preschool PTSD Treatment, Parent/Child Interaction Therapy, Child/Parent Psychotherapy
    - Behavioral Health Services – outpatient therapy by licensed practitioners
    - DME – specific coverage criteria for disposable (Elastomeric) infusion pumps
    - Professional Services – Transcranial Magnetic Stimulation, Glossary and Acronyms
    - Information Bulletins related to reimbursement
    - Providers can go to the link at the top of the slide and they can see the updates there

Discussion:
- K. Clement: Is anyone using the 275 transaction that is on the call? Has it been helpful? We're hoping that this implementation has made it easier for claim submission when supporting documentation is needed.
- No response.
- K. Viator: It may be helpful to expand the invite to some of the billing companies that have worked on behalf of practices across the state to provide us that recommendation or if that can take us into a further conversation about this.
- K. Clement: I want to recommend for both the complaints and provider disputes to use the NaviNet submission. We implemented that option to our providers last year and it is more efficient, and it is easier

	for provider submission and the response is quicker. If you are not registered to NaviNet, please contact your Account Executive and they can walk you through that process. We are really trying to get out of the hard copy forms and "snail mail" and we want to remind everyone that NaviNet has a lot of resources within the portal to provide an easier process to request claims reconsideration. Also, I want to add that your recoupment letters are also in the NaviNet portal. Often times providers receive recoupment letters to their location address and the finance department sends it and with mail it can be a bit delayed, and time is of the essence because you have 45 days from the date on the letter to dispute the recoupment. So now the Plan has the recoupment letter stored in NaviNet for easy access which is another reason to register to NaviNet and you can go in weekly and check to see what is available to you. ➢ A. Olayanju (sent in Chat): NaviNet promotion for authorization submissions as well. ➢ K. Clement: Also, the authorization submissions are in NaviNet. There's a lot of great resources in NaviNet to make it easier for you to work with our Plan. If there are any improvements that you would like to discuss with us, please reach out to your Account Executive and they will set up some time for you to sit down and talk with us because we always open for opportunities to improve. ➢ B. Robertson: Thank you, Kelli. Does anyone have any questions about NaviNet or about the claims dispute process? ➢ No response. ➢ B. Robertson: As a reminder, with NaviNet, if you're doing a claim dispute and you have medical records that you need to submit to support your dispute, you're allowed to add attachments as well. Once you submit the dispute on NaviNet, you receive an automated message letting you know that we did receive it. The time frames are still the same. We would process within 30 days, and you'll receive a response either by remit or letter letting you know that it was upheld. Any questions? ➢ No response.			
X. Open Discussion	None.			
XI. Adjournment	Bridgette Robertson announced the next PAC meeting will be held on December 18, 2024 and adjourned the meeting at 1: 56 p.m. (CST). Respectfully submitted by: Kelli Clement, Director Provider Network Operations Date *Kelli Clement* 10-1-24 Recorder: Nancy Thibodeaux, Provider Network Analyst, Provider Network Operation *Nancy Thibodeaux*			