

AmeriHealth Caritas Family of Companies Medicaid Policy and Procedure

Supersedes: State-specific ACFC Health
Plan versions of this policy

Policy Number: UM.003

Subject: Standard and Expedited Prior Authorization of Services

Department(s): Utilization Management

Current Effective Date: 06/2025

Last Review Date: 06/2025

Original Effective Date: 11/11/2022

Next Review Date: 06/2026

Applicable Lines of Business:

- | | |
|--|--|
| <input checked="" type="checkbox"/> 100: Keystone First | <input checked="" type="checkbox"/> 7100: AmeriHealth Caritas Delaware |
| <input checked="" type="checkbox"/> 500: AmeriHealth Caritas Pennsylvania | <input checked="" type="checkbox"/> 7200: Community HealthChoices (KFCHC, ACPCHC) |
| <input checked="" type="checkbox"/> 2100: AmeriHealth Caritas Louisiana | <input checked="" type="checkbox"/> 900: AmeriHealth Caritas New Hampshire |
| <input checked="" type="checkbox"/> 2400: Select Health of South Carolina | <input checked="" type="checkbox"/> 1200: AmeriHealth Caritas North Carolina |
| <input checked="" type="checkbox"/> 2600: Blue Cross Complete | <input checked="" type="checkbox"/> 7700: AmeriHealth Caritas Ohio |
| <input checked="" type="checkbox"/> 5400/5410: AmeriHealth Caritas District of Columbia | |
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Scope

This policy applies to the following AmeriHealth Caritas Family of Companies (ACFC) business operations.

Member is defined as enrollee, participant, recipient or beneficiary.

As necessary to comply with local state regulations, the contents of this policy may be copied into a stand-alone document for a specific business operation.

Purpose

To define a consistent process for Prior Authorization of Non-Urgent and Urgent services requiring Prior Authorization and a list of services/ service categories that require Prior Authorization.

Policy

Services requiring Prior Authorization are selected on the basis of:

1. Availability of evidenced based guidelines to evaluate the medical necessity of services.
2. Recognition that unexplained variation exists among practitioners in the utilization of selected services.

Services and categories of services which require Prior Authorization are listed in Attachment A: *State Specific Information and Prior Authorization List*. Prior Authorization is performed by Utilization

Management (UM) staff including nurses and licensed behavioral health (BH) and Substance use disorder (SUD) clinicians who are supported by licensed physicians. Prior Authorization decisions are based on nationally accepted guidelines (UM Medical Necessity Criteria and are no more restrictive in the services or service limits than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulation, the State Plan, and other State policy and procedures. UM staff can approve requested services when UM Medical Necessity Criteria have been met. Any decision to deny, alter, or approve coverage for an admission, service, procedure, or extension of stay in an amount, duration, or scope that is less than requested is made by the AmeriHealth Medical Director, Behavioral Health Medical Director, or physician designee after evaluating the individual health needs of the Member, characteristics of the local delivery system and, as needed, consultation with the treating physician.

ACFC will not require female Members to obtain a referral or prior authorization to women's health specialists within the network for covered care necessary to provide women's routine and preventive health care services. ACFC will allow female Members direct access to a women's health specialist in addition to the Member's designated source of primary care if that source is not a women's health specialist.

Prior Authorization determinations are documented in the appropriate information system to facilitate claim payment and are communicated to the facility in accordance with Policy UM.010, *Decision Response Time*. AmeriHealth's UM information system generates and stores an authorization number and the effective dates of the authorization to servicing and requesting Practitioners/Providers, regardless of contracted status. Any decision to deny or limit coverage is communicated in writing to the facility, attending physician, and/or Member in accordance with Policy UM.017, *Notification of Action for Adverse Benefit Determination*.

All information with PHI is handled in accordance with Policy 669.213 *Safeguards to Avoid Unauthorized Use or Disclosure of Protected Health Information, Personally Identifiable Information, and/or Certain Sensitive Demographic Data* and related policies listed in the Related Procedures section, unless otherwise required by Law or regulation.

Definitions

N/A

Procedure

A. Prior Authorization Process

1. Requests for Prior Authorization are submitted electronically, by telephone, fax, or written request to the AmeriHealth Utilization Management (UM) department. Prior Authorization Requests may be submitted by the Practitioner/Provider ordering the service or performing the service or by the Member.

Health Care Practitioners/Providers will complete the designated prior authorization form with the information to have the service considered for authorization which includes but is not limited to diagnosis code and requested item/procedure.

2. UM staff reviews the request to determine if the item/service meets guidelines to be reviewed for medical necessity. If an administrative denial is applicable (except when otherwise specified in the state specific contract and/or state regulation), notification of the determination is made in accordance with Policy UM.017, *Notification of Action for Adverse Benefit Determination* and Policy UM.906 *Administrative Denial*. If the request is for a Member under the age of 21, the request is reviewed as outlined in the EPSDT review process documented in Policy UM.300 *EPSDT Authorization Review Process for Members under the age of 21* to determine if the treatment or health service is medically necessary to treat, prevent or improve a health problem (See Policy PH.520 - *Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) and Follow-up Services*).
3. For services covered under AmeriHealth Caritas (See Policy *UM.500 Covered Benefits and Services*) the UM staff reviews the information submitted in support of the request against the definition of Medically Necessary and applicable UM Medical Necessity criteria (See Policy UM.008, *Utilization Management Criteria*). Both Standard and Expedited Prior Authorization requests are reviewed in accordance with the timeframes outlined in Policy UM.010, *Decision Response Time*.
4. Neither the Member nor the Provider is required to obtain prior authorization for Emergency Services. Emergency Services and post-stabilization services are considered those that occur in a hospital emergency room, in accordance with Policy UM.905 – *Emergency Room Services*.
5. Elective or planned admissions to a psychiatric unit are not considered emergency care and prior authorization is required. Providers are required to prior authorize elective behavioral health inpatient hospitalizations.
6. AmeriHealth staff is available 24 hours a day, 365 days a year. If services are deemed to meet medical necessity, services are authorized effective the date the request was made.
7. ACFC will gather the minimum information needed to complete the medical necessity review, the information gathered for use in a Prior Authorization determination may include some or all of the following:
 - a) Medical history
 - b) Mental Health and Substance Use History
 - c) History of present illness
 - d) Presenting symptoms
 - e) Prior treatment outcomes
 - f) Current clinical status
 - g) Plan of care
 - h) ER treatment
 - i) Current treatment
 - j) Discharge plan
 - k) Information regarding condition and instructions prior discharge if readmission is at the same contracted facility

8. If there is insufficient information to make a determination, the UM staff will request additional information in accordance with the procedure outlined in Policy UM.010, *Decision Response Time*. Lack of sufficient information may include, but not limited to:
 - a) Lack of information indicating/supporting that the service is Medically Necessary
 - b) Lack of consultant findings
 - c) Lack of therapy evaluations
9. The UM Reviewer may make a determination that coverage for the requested service(s) is Medically Necessary based on AmeriHealth's accepted UM Medical Necessity criteria (See Policy UM.008, *Utilization Management Criteria*). The requesting Practitioner/Provider, facility, and/or Member are notified of this determination as outlined in Policy UM.010, *Decision Response Time*.
10. If the UM Reviewer is able to approve the requested service or item, the UM Reviewer will notify the Member and Provider within the required timeframes as outlined in the Decision Response Time Policy. Members and Providers will receive written notification of the approval.
11. If the UM Reviewer is not able to approve the requested service(s) he/she will refer the case to the Medical Director, BH Medical Director, or physician designee for review.
12. Under no circumstances may the UM Reviewer deny, alter or approve a lower or different level of care or scope of services than requested; any such denial or downgrade must be made by either the Medical Director, BH Medical Director, or physician designee (such as a specialist from an Independent Review Organization) and based on sound clinical evidence.
13. The Medical Director/BH Medical Director or physician designee reviews the clinical information submitted in support of the request and documents the determination in the medical management information system. He/She may also consult a specialty Practitioner/Provider for input into the determination (Policy UM.315 *Independent Consultant Review*).
14. If the needed and approved level of care for SUD treatment is not available, ACFC will authorize the next highest level of care for SUD treatment.
15. The UM Reviewer is responsible for communicating the Medical Director, BH Medical Director or physician designee's determination electronically, by fax, phone call and/or written notification to the requesting Practitioner/Provider, facility, and /or Member as outlined in Policy UM.010, *Decision Response Time*.
16. If the Medical Director, BH Medical Director, or physician designee's determination is to deny, alter, or approve a lower or different level of care or scope of services other than requested, the written notification to the requesting Practitioner/Provider and/or Member includes the rationale for the determination and applicable appeal rights as outlined in Policy UM.017, *Notification of Action for Adverse Benefit Determination* by the clinical staff / UM Reviewer.
17. At the time of the electronic, fax or verbal notification of the Adverse Benefit Determination, the Practitioner/Provider is given the opportunity to call and discuss the Adverse Benefit Determination with the Medical Director/physician designee who made the determination or his/her designee (See Policy UM.105, *Peer- to-Peer Discussion*).

18. Members, Practitioners acting on behalf of the Member with the Member's consent, or Member's Authorized Representative may file a Grievance or an Appeal of an Adverse Benefit Determination in accordance with the ACFC Appeal and Grievance policy.

Related Policies

See also - Policy 669.235 *HIPAA Definitions*

See also - Policy 669.213 *Safeguards to Avoid Unauthorized Use or Disclosure of Protected Health Information, Personally Identifiable Information, and/or Certain Sensitive Demographic Data*

See also - Policy 669.227 *Use and Disclosure of Protected Health Information without Member Consent or Authorization*

See also - Policy 591.001 *Records Retention Policy & Schedule*

See also - Policy UM.001 *Glossary of Terms*

See also - Policy UM.008 *Utilization Management Criteria*

See also - Policy UM.010 *Utilization Management Decision Response Time*

See also - Policy UM.017 *Notification of Adverse Benefit Determination*

See also - Policy UM.105 *Peer-to-Peer Discussion*

See also - Policy UM.315 *Independent Consultant Review*

See also - Policy UM.500 *Covered Benefits and Services*

See also - Policy UM.905 – *Emergency Room Services*

See also - Policy UM.300 *EPSDT Policy*

See also – Policy UM.906 *Administrative Denial*

Source Documents & References

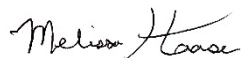
MCO Standards for Accreditation - National Committee for Quality Assurance (NCQA), Utilization Management Standards

Code of Federal Regulations including but not limited to: 438.210, 438.208, 438.910

Attachments

Attachment A: State Specific Information and Prior Authorization List (State / Plan Name)

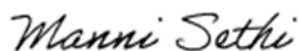
Approved by



Melissa Haase

Vice President, Utilization Management Operations

Date: 11/7/2025



Manni Sethi, MD

Corporate UM Medical Director

Date: 11/7/2025

Revision Date	Revision
12/2023	Annual Review. Added applicable CFRs under Resources
11/2024	To further explain how criteria is used, the following sentence was added to page 2, 1 st paragraph "...and are no more restrictive in the services or service limits than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulation, the State Plan, and other State policy and procedures. "
06/2025	<p><u>Edits made to policy for clarification and add policy reference. , Added reference to policy UM.500.NX Covered Services to policy procedure and to related policy list.</u></p> <p><u>Edited bullet 5 to read elective or planned admissions to a psychiatric unit is not considered emergency care and prior authorization is required. Providers are required to prior authorize elective behavioral health inpatient hospitalizations.</u></p>
10/31/2025	<u>Updated page 5, Procedure step #2 to further explain administrative denials to be administered when appropriate if not excluded in the state's contract or state regulations.</u>

AmeriHealth Caritas Family of Companies

Medicaid Policy Addendum

Territory: AmeriHealth Caritas Louisiana

Addendum Number: UM-A.003.LA

Subject: UM Standard & Expedited Prior Authorization of Services

Department(s): Utilization Management

Current Effective Date:

11/19/2025

Last Review Date: 11/19/2025

Original Effective Date: 8/30/2023

Next Review Date: 11/2026

ACLA UM policies and procedures include service authorization policies and procedures consistent with 42 CFR §438.210, 42 CFR §441 Subpart D, state laws and regulations, Medicaid State Plan and waivers, and the court-ordered requirements of Chisholm v. Gee and Wells v. Gee for initial and continuing authorization of services. Opioid Treatment Programs (OTPs) must adhere to all policies, rules and regulations set forth by the LA Department of Health; Office of Behavioral Health, State Opioid Treatment Authority. Services shall be provided in accordance with the standards set forth by the Substance Abuse and Mental Health Service Administration (SAMHSA), Health Standards Licensing, the US Department of Justice Drug Enforcement Administration (DEA), the LA Board of Pharmacy and all applicable SAMHSA approved accrediting bodies as accepted by the LA Department of Health.

ACLA associates review all requests for service authorization to reduce inappropriate and duplicative use of health care services. Services are reviewed for being sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligible Enrollees under the Medicaid State Plan. ACLA shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the Enrollee. ACLA may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services and family planning with freedom of choice for method to be used), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.

ACLA shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any Enrollee in accordance with 42 CFR §438.6(i), 42 CFR §422.208, and 42 CFR §422.210. Any decision to deny a service authorization request or to authorize a service in an amount, duration or score that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

All Medical Necessity Reviews are performed by licensed qualified clinicians, including nurses and licensed mental health and substance abuse clinicians who are supported by licensed physicians. Only licensed clinical professionals (ACLA Medical Director, ACLA Behavioral Health Director, or physician designee) with appropriate clinical expertise in the treatment of an Enrollee’s condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested. Any decision to deny, alter or approve coverage for an admission, service, procedure or extension of service in any amount, duration or scope that is less than requested is made by the ACLA Medical Director/ACLA Behavioral Health Medical Director, or physician designee) after evaluating the individual health needs of the Enrollee, characteristics of the local deliver system and, as needed, consultation with the treatment physician. The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise substantial question as to the clinical peer reviewer’s physical, mental, or professional or moral character. Review decisions are based on nationally accepted guidelines as outlined in ACLA Policy #UM.008.LA, Utilization Management Clinical Criteria.

ACLA shall have written procedures listing the information required from an Enrollee or health care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall outline the process to be followed in the event ACLA determines the need for additional information not initially requested.

ACLA shall have written policies and procedures to address the failure or inability of a provider or Enrollee to provide all necessary information to process requests for initial and continuing authorizations of services. If the necessary information is not released or provided to ACLA, ACLA may deny authorization of the requested service(s) within two (2) business days.

The Enrollee (or provider/agent on behalf of the Enrollee) is provided with information on the opportunity to present evidence, and allegations of fact or law, in person as well as in writing, within the Enrollee and provider handbook and on the ACLA website www.amerihhealthcaritasla.com.

Service/Program	ACLA State Distinction	Reference/Source
<p><i>Prior Authorization Process Procedure- LA Medicaid Provider Enrollment Status</i></p>	<p>Upon receipt of request for service from an OON provider, the Look-Up Tool should be used to confirm the providers’ enrollment with LA Medicaid prior to issuing a prior authorization for service(s).</p> <ul style="list-style-type: none"> • Providers not enrolled with LA Medicaid will receive a prior authorization denial in accordance to policy <i>UM.904.LA Authorization</i> 	<p>2.12.3 Prior Authorization 2.12.6.3.2 – Post Service Authorization</p>

	<i>of Non-Participating Providers and UM.017.LA Adverse Benefit Determination</i>	
<i>Availability of Criteria</i>	Utilization Management medical necessity criteria and practice guidelines shall be disseminated to all affected providers, Enrollees and potential Enrollees. ACLA shall ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the clinical practice guidelines.	2.12.12.5-2.12.12.6;
<i>General Service Authorization Requirements</i>	<p>ACLA shall develop and implement written procedures including, but not limited to, the following:</p> <p>A process to ensure that authorization requirements of ACLA shall either be furnished to the healthcare provider within twenty-four (24) hours of a request for the requirement (Effective 01/01/2026: forty-eight (48 hours)).</p> <p>In addition, ACLA shall post a list of all items and services that require prior authorization in an easily searchable format, that includes the date of last review, on ACLA's public website. ACLA shall furnish these requirements to Providers in addition to the Prior Authorization information and training that must be furnished under the Provider Services and</p>	2.12.3.6; 2.12.3.6.4

	Support section	
<i>SBHS Medical Necessity Methodology</i>	<p>For SBHS, ACLA shall provide the following for each unique service:</p> <ul style="list-style-type: none"> • Any Prior Authorization requirements; • Number of pass-through visits or Encounters permitted as applicable • Detailed medical necessity criteria and source • Clinical documentation required for Prior Authorization and decision-making • Comprehensive Service Authorization criteria and source used by ACLA's staff to determine whether a service should be approved or partially denied; and • Standard authorization period. 	2.12.1.2.1.1- 2.12.1.2.1.1.6
<i>Service Authorization Criteria- CPST and PSR</i>	<p>ACLA shall establish and implement a six (6) month Service Authorization period for CPST and PSR service unless otherwise approved by LDH based on justification provided by ACLA.</p>	2.12.4

<i>Post Authorization</i>	<p>ACLA shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous Service Authorization approval, unless the approval was based upon a material omission or misrepresentation about the Enrollee’s health condition made by the provider.</p> <p>ACLA shall not use a policy with an effective date subsequent to the original Service Authorization request date to rescind its Prior Authorization.</p>	2.12.6.3.2- 2.12.6.3.3
<i>Public Health Quarantine</i>	<p>A public health quarantine or isolation order or recommendation also establishes the medical necessity of healthcare services.</p>	2.4.1.5.1
<i>Enrollee Request for Provision of Services</i>	<p>ACLA shall provide a mechanism in which an Enrollee may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its Enrollee manual and incorporated in the grievance procedures.</p>	2.12.3.6.6
<i>Respiratory Viral Panels</i>	Effective 9/1/2024	LDH Informational Bulletin 24-31 September 18, 2024: Coverage of Respiratory Viral Panels (87631, 87632, 87633).

Service Category	ACLA Services Requiring Prior Authorization
<i>Transportation</i>	<ul style="list-style-type: none"> • Non-Emergent Air Ambulance
<i>Out of Network</i>	<ul style="list-style-type: none"> • All out-of-network services (with exceptions noted under: Does not require authorization).
<i>Audiology</i>	<ul style="list-style-type: none"> • Cochlear Implantation
<i>OB GYN Related Services</i>	<ul style="list-style-type: none"> • Hysterectomy (consent form required) • Elective Abortions
<i>Transplant</i>	<ul style="list-style-type: none"> • Transplant evaluations • Transplant Surgery
<i>Inpatient Services</i>	<ul style="list-style-type: none"> • All inpatient hospital admissions, including medical, surgical and rehabilitation within one (1) business day of admission • Obstetrical admissions exceeding the following; <ul style="list-style-type: none"> ○ 48 hours after vaginal delivery ○ 96 hours after Cesarean section • In-patient medical detoxification • Elective transfers for inpatient and/or outpatient services between acute care facilities. • Skilled Nursing Facility (SNF) (short-term) initial placement if still enrolled with the plan. • Long Term Acute Care (LTAC)
<i>Home-based Services</i>	<ul style="list-style-type: none"> • Home Health Care PT, OT, ST) and skilled nursing visits (after 18 combined visits, regardless of modality). • Private Duty Nursing (Extended Nursing Services) (covered when medically necessary for under age 21) • Personal Care Services (covered when medically necessary for under age 21) • Home Health Extended Services • Home Infusions & Injections (please see HCPCS Code list requiring authorization on Attachment C) • Enteral Feedings, including related DME

Service Category	ACLA Services Requiring Prior Authorization
<i>Therapy and Related Services</i>	<ul style="list-style-type: none"> • Outpatient facility-based speech and occupational therapy • Private/professional and outpatient facility physical therapy • Chiropractic Care (Age 0-20) • Cardiac Rehabilitation
<i>DME</i>	<ul style="list-style-type: none"> • All Rentals • Custom DME, orthotics and prosthetics • Wheelchair parts • DME for billed charges \$750 and over • Diapers/Pull-ups (ages 3-20) who qualify: <ul style="list-style-type: none"> ▪ Quantities over 200/month for either or both ▪ Brand specific diapers
<i>Implants</i>	<ul style="list-style-type: none"> • >\$750
<i>Hyperbaric Oxygen</i>	
<i>Medications</i>	<ul style="list-style-type: none"> • Physician-administered infusions and injectable based on medication's HCPCS code (see link to comprehensive list) <p>https://www.amerithealthcaritasla.com/pdf/provider/resources/priorauth/hcpcs-codes-requiring- authorization.pdf</p>
<i>Surgical services that may be considered cosmetic (not an all-inclusive list)</i>	<ul style="list-style-type: none"> • Blepharoplasty • Mastectomy for Gynecomastia • Mastopexy • Maxillofacial • Panniculectomy • Penile Prosthesis • Plastic Surgery/Cosmetic Dermatology • Reduction Mammoplasty • Septoplasty
<i>Pain Management</i>	<ul style="list-style-type: none"> • External infusion pumps • Spinal cord neurostimulators • Implantable infusion pumps • Radiofrequency ablation and nerve block

Service Category	ACLA Services Requiring Prior Authorization
<i>Radiology Services</i>	<ul style="list-style-type: none"> • CT Scan • MRI • MRA • Nuclear Cardiac Imaging • PET Scans for Oncologic Conditions
<i>Ultrasounds</i>	<ul style="list-style-type: none"> • Authorization required after first 3 (three) for pregnant Enrollees being treated by a par provider
<i>All unlisted, miscellaneous, and manually priced codes</i>	
<i>Physical Health In Lieu of Service(s)</i>	<ul style="list-style-type: none"> • Remote Patient Monitoring (effective date: 7/1/2023) • Hospital-based Care Coordination for pregnant and postpartum individuals with substance use disorder and their newborns • Doula Services • Chiropractic services (adults 21 and older) after first 18 treatment visits annually • Outpatient lactation support
<i>Bariatric Surgery</i>	<ul style="list-style-type: none"> • Gastric Bypass • Vertical Band Gastroplasty
<i>Behavioral Health</i>	<ul style="list-style-type: none"> • All out-of-network services • Community Brief Crisis Support (CBCS) • DOJ Agreement Target Population: <ul style="list-style-type: none"> • Electroconvulsive Therapy (ECT) • Individual Placement Support Services • Personal Care Services • Psychiatric Residential Treatment Facility (PRTF) • Psychiatric In-patient services • Psychoanalysis • Psychological and Neuropsychological Testing • Crisis Stabilization Youth (age 0-20) • Crisis Stabilization Adults (age 21 and older) • Adult Community Psychiatric Supportive Treatment (CPST)
	<ul style="list-style-type: none"> • Child and Adolescent Community Psychiatric Supportive Treatment

(CPST) that also includes:

- Homebuilders (HB)
- Functional Family Therapy (FFT)
- Multi-systemic Therapy (MST)
- Short-term residential care in Therapeutic Group Home (TGH)
- Assertive Community Treatment (ACT) Enrollees aged 18 and up
- Peer support services (PSS)
- Adult Psychosocial Rehabilitation Services (PSR)
- Child and Adolescent Psychosocial Rehabilitation (PSR)
- Substance Use Disorder (SUD) Halfway House (ASAM Level 3.1)
- Long Term Residential Care (Adult only ASAM Level 3.3)
- Substance Use disorder Acute Detoxification (prior authorization required when 6 or more days of services is provided)
- Substance Use Disorder Sub-acute Detoxification (prior authorization required when 6 or more days of services is provided)
- Substance Use Disorder (SUD) Adult & Child/Adolescent Treatment Program (ASAM Level 3.5)
- Substance Use Disorder (SUD) Adult Treatment Program (ASAM Level 3.7)
- Substance Use Disorder (SUD) Intensive Outpatient Program (ASAM Level 2.1)
- In Lieu of Services:
 - Residential SUD in freestanding facility (IMD) for adults 21-64 years old
 - SUD ASAM Level 3.1: Halfway House
 - SUD ASAM Level 3.2-WM: Sub-acute Detox
 - SUD ASAM Level 3.3: Behavioral Health Long Term Residential
 - SUD ASAM Level 3.5: Residential Treatment
 - SUD ASAM Level 3.7: Adult Treatment
 - SUD ASAM Level 3.7WM: Acute Detox

	<ul style="list-style-type: none"> ○ Freestanding Psych Hospital / IMD for adults ages 21-64 ○ Therapeutic Day Center (age 5-20) ○ Mental Health Intensive Outpatient Program
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<ul style="list-style-type: none"> ● <i>Applied Behavior Analysis (ABA) Therapy (age 0 – 20)</i> 	
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<ul style="list-style-type: none"> ● <i>Respiratory Viral Panel (CPT 87631, 87632, 87633) (Effective 9/1/2024)</i> 	<p>CPT 87631- deemed medically necessary in the following instances:</p> <ul style="list-style-type: none"> ● Infants receiving monthly RSV prophylaxis with palivizumab because of high-risk conditions such as prematurity, respiratory disease or cardiac disease. ● Long-term care facility residents returning to a facility, or a person of any age returning to a congregate setting. <p>CPT 87632 and 87633 deemed medically necessary in the following instances:</p> <ul style="list-style-type: none"> ● Beneficiaries with serious or critical illness or at imminent risk of becoming seriously or critically ill, immunodeficiency, and/or severe underlying condition contributory to testing using an expanded syndromic panel. ● Testing is approved for the following places of service (POS) without authorization: <ul style="list-style-type: none"> ○ 19 – off-campus outpatient hospital, ○ 21 – inpatient hospital, ○ 22– on-campus outpatient hospital, ○ 23 – emergency room. ● Tests should be ordered as follows (for healthcare POS other than those listed in the above bullet): Testing for these services should only occur in accordance with one or more of the following instances: <ul style="list-style-type: none"> ○ For immune-competent beneficiaries, the test must be ordered by an infectious disease specialist or pulmonologist who is diagnosing and treating the beneficiary. ○ For immune-compromised beneficiaries, the test must be ordered by a clinician specialist in one of the following: infectious diseases, oncology, transplant (for any panel), or pulmonologist who is diagnosing and treating the beneficiary. ● POS exception: an exception may be made within geographic locations where the specialist(s) cannot be reasonably reached by the beneficiary; AND the beneficiary is under the care of one of these providers: infectious diseases, oncology, transplant (for any panel), or pulmonologist; AND the ordering provider is located closer to the beneficiary’s place of residence than the nearest specialist. ● This exception is intended for beneficiaries living in rural locations with limited clinical specialist access only.
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Service Category	ACLA Services Not Requiring Prior Authorization/Notification/Referral
<i>Transportation</i>	<ul style="list-style-type: none"> • Emergency Air Ambulance Services
<i>Emergency Room Services</i>	<ul style="list-style-type: none"> • Services in and out of network • Post-stabilization services (both in and out of network)
<i>Observation</i>	<ul style="list-style-type: none"> • 48-Hour Observations (except for Maternity- notification required)
<i>Dialysis Services</i>	<ul style="list-style-type: none"> • Services rendered at freestanding or hospital-based outpatient dialysis facilities
<i>Radiology Services</i>	<ul style="list-style-type: none"> • In-Network: • Low-level plain films • x-rays • EKGs
<i>OB/GYN Services/Deliveries</i>	<ul style="list-style-type: none"> • Women’s Healthcare by In-Network Provider • Family Planning Services (In-Network) • All non- emergency inpatient admissions for normal newborn deliveries • A PCP referral (if the PCP is not a women’s health specialist) for access to a women’s health specialist contracted with ACLA for routine and preventive women’s healthcare services and prenatal care.
<i>Eye care/Vision Services</i>	<ul style="list-style-type: none"> • PCP Referral for in-network care
<i>Ultrasounds</i>	<ul style="list-style-type: none"> • Any US performed by a Maternal Fetal Medicine Specialist • Up to 3 Ultrasounds for pregnant Enrollees being treated by a par provider.
<i>Indian Enrollees</i>	<ul style="list-style-type: none"> • may be referred from an IHCP to a network provider
<i>Continuity of Care</i>	<ul style="list-style-type: none"> • Continuation of covered services for a new Enrollee transitioning to the plan the first 30 calendar days of continued services, regardless whether services are provided by an in- network or out-of-network provider

Service Category	ACLA Services Not Requiring Prior Authorization/Notification/Referral
<i>Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)</i>	
<i>Physical Health ILOS</i>	<ul style="list-style-type: none"> • Hospital-based Care Coordination for pregnant and postpartum individuals with substance use disorder and their newborns
<i>Behavioral Health</i>	<ul style="list-style-type: none"> • 48-Hour Observations • Behavioral Health & Substance Use Disorder (SUD) Evaluations & Assessments • Behavioral Health & Substance Use Disorder (SUD) Medical Team Conference • Behavioral Health & Substance Use Disorder (SUD) Medication Evaluation, Management & Consultation • Behavioral Health & Substance Use Disorder (SUD) Outpatient Therapy (Individual, Family, Group Therapy Sessions including SUD Level 1) • Behavioral Health & Substance Use Disorder (SUD) Therapeutic Injections • Mobile Crisis Response • Dialectical Behavioral Therapy (Effective March 2024) • In Lieu of Services: <ul style="list-style-type: none"> ○ 23-Hour Observation Bed Services for all Medicaid Eligible Adults (Age 21 and Above) ○ Licensed Mental Health Professional Services for all Medicaid-Eligible Adults (age 21 and older) ○ Injection Services Provided by Licensed Nurses to All Medicaid Eligible Adults (Age 21 and Above) ○ Intensive Outpatient Program

Service Category	ACLA Services Requiring Notification
<i>Maternity Obstetrical Services</i>	<ul style="list-style-type: none"> • Notification required by the provider of Obstetrical care at the time of the first visit of the pregnancy
<i>Newborn Deliveries</i>	<ul style="list-style-type: none"> • Notification required by the provider of Obstetrical admissions and up to forty-eight (48) hours after vaginal delivery; ninety-six (96) hours after Caesarean section
<i>Behavioral Health</i>	<ul style="list-style-type: none"> • Substance Use Disorder Acute Detoxification (notification required when no more than 5 days of services are provided) • Substance Use Disorder Sub-acute Detoxification (notification required when no more than 5 days of services are provided) • Initial Crisis Intervention Mental Health Services for all ages (notification and auto- approval) • Behavioral Health Care Crisis (BHCC)

Reference/Resource:

LDH Medicaid MCO Attachment A: Model Contract Sections 2.2.5.3.1; 2.12.3.5; 2.12.6.3.2-2.12.6.3.3; 2.12.8.7

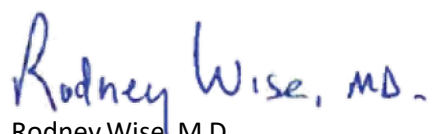
Louisiana Medicaid Managed Care Organization (MCO) Manual. In Lieu of Services.

LDH Medicaid Managed Care Organization Contract Attachment C2: In Lieu of Services.

LDH Medicaid Managed Care Organization Contract Attachment B: MCO Covered Services.

LDH Informational Bulletin 24-31 September 18, 2024: Coverage of Respiratory Viral Panels (87631, 87632, 87633).

Approved by:



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Loretta Dumontet, MD

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Behavioral Health Medical Director

Revision Date	Revision
6/8/2023	<p>Review and contract update: Transitioned policy from 153.003 Standard and (PreService) Prior Authorization plan policy to corporate base policy UM.003 Standard & Expedited Prior Authorization of Services with state specific addendum to meet plan requirement.</p> <p>Added: "ACLA shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous Service Authorization approval, unless the approval was based upon a material omission or misrepresentation about the Enrollee's health condition made by the provider" (2.12.6.3.2)</p> <p>Added process to verify provider LA Medicaid eligibility prior to issuing prior authorization for service.</p> <p>Added PH ILOS:</p> <ul style="list-style-type: none">• Doula Services• Chiropractic services for adults age 21 and older• Hospital-based Care Coordination for pregnant and postpartum individuals with substance use disorder and their newborns• Remote Inpatient Monitoring <p>Added BH ILOS:</p> <ul style="list-style-type: none">• Freestanding Psych Hospital / IMD for adults ages 21-64• Therapeutic Day Center (age 5-20)• Mental Health Intensive Outpatient Program <p>Separate category created for Applied Behavior Analysis (ABA)</p>
10/2023	<ul style="list-style-type: none">• Removed Long Term Care from IP services requiring authorization• Added: Skilled Nursing Facility (SNF)(short-term) and Long-Term Acute Care (LTAC) to IP services requiring authorization• Add Dialectical Behavioral Therapy – service no authorization required• Added authorization required for BHCC if > 23 hours or if referral made from CBCS
7/2024	<ul style="list-style-type: none">• Updated availability of criteria requirements- shall be disseminated to all affected providers, Enrollees and potential Enrollees upon request within twenty-four (24) hours. Authorization requirements must be posted to ACLA's public website.• Added SBHS medical necessity methodology (2.12.1.2.1.1- 2.12.1.2.1.1.6)• Added service authorization criteria for CPST and PSR (2.12.4)
01/2025	<ul style="list-style-type: none">• Added coverage of respiratory viral panels• Remote Patient Monitoring effective date updated to 7/1/2023• Add Outpatient Lactation Support to Physical Health In Lieu of Service(s)• Removed from Services Requiring Prior Auth:<ul style="list-style-type: none">• Crisis Intervention Follow-up Services• Behavioral Health Care Crisis (BHCC) - added to notification only table
08/12/2025	<ul style="list-style-type: none">• Added General Service Authorization Requirement (2.12.3.6-2.12.3.6.4) ACLA must post a list of all items and services that require prior authorization and must be furnished when requested by a provider

