Louisiana Medicaid
Managed Care Organization (MCO)
Manual

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LOUISIANA
DEPARTMENT OF HEALTH

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PART 1: INTRODUCTION

OVERVIEW

The **Managed Care Organization (MCO) Manual** is a compilation of policies, instructions, and guidelines established by the Louisiana Department of Health (LDH) for the administration of the Louisiana Medicaid managed care program. The purpose of this Manual is to provide clarifying information and operational guidelines to support the MCO in complying with the terms of its contract with LDH (hereinafter, the "Contract"). This Manual is intended to accompany the Contract rather than be a standalone and exhaustive compilation of contractual requirements.

This Manual applies to MCOs contracted by LDH to provide coverage for services to Louisiana Medicaid managed care program enrollees, effective January 1, 2021. This Manual also applies to major subcontractors with delegated responsibilities for the provision of all, or part, of any program area or function that relates to the delivery or reimbursement of covered services, including, but not limited to, behavioral health, claims processing, care management, utilization management, transportation, or pharmacy benefits, including specialty pharmacy providers.

The MCO is solely responsible for complying with the requirements set forth within this Manual and in the Contract whether or not subcontractors are used. In addition, the MCO is responsible for ensuring compliance by its subcontractors. In the event of a perceived discrepancy between the Contract and this Manual, the MCO shall seek clarification from LDH prior to taking action.

REVISIONS

This Manual may be revised at the discretion of LDH due to a variety of reasons, including, but not limited to, changes to any provisions of state and federal laws, regulations, rules, the Louisiana Medicaid State Plan, and waivers applicable to managed care, contract amendments, internal operational changes, and requests for written guidance in a particular area.

In accordance with Louisiana Revised Statutes La. R.S. 46:460.54, prior to adopting, approving, amending, or implementing certain policies or procedures[1] contained in the Manual, LDH will publish the proposed policy or procedure on the LDH website for a period of no less than 45 calendar days for the purpose of soliciting public comments. The public comment period will not apply if LDH finds that an imminent peril[2] to the public health,

[1] Per La. R.S. 46:460.51, "Policy or procedure" shall mean a requirement governing the administration of managed care organizations specific to billing guidelines, medical management and utilization review guidelines, case management guidelines, claims processing guidelines and edits, grievance and appeals procedures and process, other guidelines or manuals containing pertinent information related to operations and pre-processing claims, and core benefits and services.

[2] Imminent peril is defined as sudden, urgent and critical situations that call for aid to the public health, safety, or welfare that require immediate approval of a proposed policy or procedure or manual revision without otherwise publishing the proposed policy or procedure or revision as required by standard timelines required under La. R.S. 46:460.53 and 46:460.54.

safety, or welfare requires immediate adoption of the proposed policy or procedure. The public comment period also will not apply for non-material[3] revisions.

Once approved by LDH, the revised Manual will be posted on the LDH website. The MCO may subscribe via e-mail to healthy@la.gov to be notified of updates. The MCO is responsible for notifying subcontractors and executing necessary subcontract amendments when revisions are made to the Manual.

[3] Non-material revisions are defined as typographical, grammatical, formatting, or stylistic edits only, including but not limited to word changes that do not impact or affect overall content. Non-material changes have no programmatic or monetary impact on providers.

PART 2: ADMINISTRATION & CONTRACT MANAGEMENT

The MCO's business administration, organization, and oversight of all contracted responsibilities is critical to achieving LDH's goal of building a Medicaid managed care delivery system that improves the health of populations, enhances the experience of care for individuals, and effectively manages Medicaid per capita care costs.

HEALTH PLAN ADVISORIES

LDH may issue health plan advisories (HPAs) when there is a need to communicate immediate guidance—particularly in temporary or emergency situations (e.g., pandemics, natural disasters). The MCO must comply with all directives contained within HPAs.

MCOs and subcontractors can access HPAs on the LDH website [link].

BUSINESS OWNERS

LDH maintains an LDH business owner listing, which is provided to the MCOs on a monthly basis via e-mail. MCOs should distribute this listing to its staff and use it to identify the appropriate LDH contact for questions or concerns about a specific business area or report.

LDH also maintains an MCO business owner listing, which is provided to LDH staff. MCOs should provide updated contact information upon request by LDH.

MCO POLICY AND PROVIDER MANUAL SUBMISSION GUIDANCE

The MCO shall submit all new or materially amended policies, procedures, and provider manuals to MCOPolicies@la.gov. A brief description should be provided in the subject line. Submissions of materially amended policies, procedures, and provider manuals shall include a single document containing the existing policy, procedure, or provider manual with the proposed revisions redlined.

E-mails must not be sent to specific individuals or to ProviderRelations@la.gov.

In accordance with La. R.S. 46:460.54, prior to approving any policy or procedure, LDH will publish the proposed policy or procedure on the LDH website for a period of no less than 45 calendar days for the purpose of soliciting public comments. The public comment period will not apply if LDH finds that an imminent peril to the public health, safety, or welfare requires immediate adoption of the proposed policy or procedure. The public comment period also will not apply for non-material revisions. A policy or procedure proposed by an MCO shall not be implemented unless LDH has provided its express written approval to the MCO after the expiration of the public

notice period. Additionally, the MCO shall notify its network providers at least 30 calendar days prior to implementation of a new or revised policy or provider manual change.

LEGAL COMPLIANCE

This section provides additional information or guidance related to court-ordered requirements.

AJ v. LDH

This section explains the class-action lawsuit titled *A.J., a minor child by and through his mother, Donnell Creppel, et al., versus the Louisiana Department of Health, et al.*, 3:19-CV-00324 (hereinafter, "*AJ v. LDH*") and the implementation and operation of key provisions of the settlement agreement in that litigation. Refer to the Home Health chapter of the **Medicaid Services Manual** for general policies about home health services not specific to *AJ v. LDH*.

Member Class

Class members in *AJ v. LDH* are defined as follows: All current and future Medicaid beneficiaries under the age of 21 in Louisiana who are certified in the Children's Choice Waiver, the New Opportunities Waiver, the Supports Waiver, or the Residential Options Waiver who are also prior authorized to receive extended home health (EHH) services or intermittent nursing (IN) services which do not require prior authorization but are not receiving some or all of the hours of extended home health services or intermittent nursing services as authorized by Louisiana Medicaid.

Litigation Summary

AJ v. LDH, filed on May 22, 2019, seeks to enforce rights under the EPSDT and reasonable promptness mandates of Title XIX of the Social Security Act, the Americans with Disabilities Act [42 U.S.C. §12131, *et seq*.], and Section 504 of the Rehabilitation Act [29 U.S.C. §794] by compelling the Department to arrange for the in-home skilled nursing care prior authorized for Medicaid-enrolled, medically fragile children. Because of their medical needs, class members have been prior authorized to receive EHH services to be able to live in the community. Data reflect gaps between the EHH service amounts prior authorized and the EHH service amounts actually delivered to class members. Potential service gaps in medically necessary IN services to class members also fall under the scope of the litigation. The suit has been settled, and the corresponding settlement agreement was approved by the court on March 31, 2020.

Prohibited Acts

MCOs are prohibited from reducing prior approved EHH service amounts for class members to increase the percentage of prior approved EHH services actually delivered. Such reduction in the amount of services that have been prior approved is contrary to federal Medicaid law and would constitute a due process violation under the United States Constitution.

Settlement Implementation

Implementation of the settlement by MCOs is discussed more fully below.

Crisis Response Team

Louisiana Medicaid has established a Crisis Response Team (CRT), the primary responsibility of which is arranging for in-home nursing services for class members when such services are unavailable through existing Medicaid home health agencies within the class member's LDH region. The MCO is responsible for accepting referrals from the CRT and arranging service fulfillment.

Support coordinators or case managers have the obligation promptly to make referrals to the CRT for any class member who, after making reasonable efforts to receive EHH or IN services:

- Has received less than 90% of his or her prior approved EHH or medically necessary IN services for at least two consecutive weeks; or
- Has been unable to locate a home health provider in his or her LDH Region or has been denied enrollment by all home health providers in his or her LDH Region; or
- Is otherwise facing a serious risk of institutionalization due to lack of EHH or IN services.

In addition, when a need for IN has been identified and a class member is being terminated from existing EHH services where the class member's LDH region does not have a provider for IN services on the date that the notice of denial has been sent, the class member must be immediately referred to the CRT. In such situations, a reasonable effort includes a reevaluation of whether or not the class member should have been found eligible for EHH services.

The CRT operates in addition to, and does not replace, the responsibilities of a class member's existing support coordinator or case manager.

The MCO is responsible for submitting a monthly report to LDH documenting the actions taken by the MCO to ensure service provision and fulfillment for CRT referral members. The MCO is also responsible for submitting a monthly report detailing the hours and service provision for class members.

Class Member Denial Notices

Notices to class members denying EHH services must contain contact information for the CRT when there is an identified need for IN services, i.e., for in-home skilled nursing services of visits with a duration shorter than three contiguous hours per day.

Contact information for the CRT is as follows:

- E-mail: crisisresponseteam@la.gov
- Telephone: (866) 729-0017

Additionally, in situations when a class member is being referred to the CRT due to the unavailability of a provider for IN services concurrent with a termination from existing EHH services, the notice of denial to the class member of the EHH services termination must also notify the class member of the referral to the CRT.

Case Management

Support coordinators or case managers must document in the progress notes for each class member all prior approved EHH or medically necessary IN services and whether those EHH or IN services are provided, as reported by the family, including whether the family has refused the offered services and, if so, the basis for the refusal.

Additional Rate Modifiers

Louisiana Medicaid has published a Home Health Services Fee Schedule that includes modifiers with enhanced rates for situations in which two beneficiaries are cared for simultaneously, for children in EHH with high medical needs, for overnight shifts for EHH, for weekend shifts for EHH, for holiday shifts for EHH, and for EHH services in rural areas. These rate modifiers may be used in applicable circumstances to provide an enhanced reimbursement rate to home health providers in order to facilitate fully staffing prior approved EHH services for class members.

A home health agency may also submit claims using the TU modifier to identify hours for an EHH enrollee that were paid as overtime to the nurse delivering the care. This modifier shall not require prior authorization but must be for hours already authorized for the enrollee. When billing, this modifier may be used in addition to any other authorized modifiers (e.g., TG) for procedure codes S9123 and S9124, but shall be paid at a minimum of 1.5 times the base rate of the procedure code.

The use of this modifier is subject to post-payment review. The MCO shall require the home health agency to maintain all necessary documentation to support the use of this modifier. Non-compliance with written policy may result in recoupment and additional sanctions, as deemed appropriate by Louisiana Medicaid.

Termination

The settlement period for *AJ v. LDH* is scheduled to terminate on March 31, 2025, unless otherwise ordered by the court.

Chisholm v. LDH

Class members in *Chisholm v. LDH* (Case 2:97-cv-03274) are defined as follows: All current and future beneficiaries of Medicaid in the state of Louisiana under age twenty-one who are now on or will in the future be placed on the Developmental Disabilities Request for Services Registry.

The MCO shall comply with all court-ordered requirements as directed by LDH, including, but not limited to, guidance provided in the **Chisholm Compliance Guide** and accompanying **MCO User Manual**.

DOJ Agreement

The target population of the Department of Justice (DOJ) Agreement (Case 3:18-cv-00608, Middle District of Louisiana) are defined as follows: (a) Medicaid-eligible individuals over age 18 with serious mental illness (SMI) currently residing in nursing facilities; (b) individuals over age 18 with SMI who are referred for a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation of nursing facility placement during the course of this Agreement, or have been referred within two years prior to the effective date of this Agreement; and (c) excludes those individuals with co-occurring SMI and dementia, where dementia is the primary diagnosis.

The MCO shall comply with all court-ordered requirements as directed by LDH, including, but not limited to, guidance provided in the **DOJ Agreement Compliance Guide**.

Monitoring of Denial Notices

LDH monitors denial and partial denial notices to ensure compliance with federal requirements regarding timely and adequate notices of benefit determinations for prior authorized services. An auditing and monitoring process was established following the *Wells v. Gee* litigation (Case 3:14-cv-00155).

As a result of the joint stipulation from the *Wells v. Gee* settlement, LDH developed multiple templates to help the MCOs maintain compliance with federal requirements as it pertains to the development of denial and partial denial notices of prior authorized services. LDH strongly encourages continued use of these templates as a resource tool to assist with compliance. See the *Resources* section for a link to these templates.

PUBLIC RECORDS' REQUEST PROTOCOL

LDH and MCOs agree that timely responding to public records act requests ("PRR") is an important facet of the LDH/MCO relationship. These protocols are designed to facilitate a collaborative approach aimed at allowing LDH to promptly respond to these requests in accordance with law. PRRs may be presented that call for responses, and effort to create these responses, that range from simple to complicated. LDH and MCOs agree that collaborative cooperation founded upon early and frequent communications between both sides can be helpful. These communications could serve to refine a request to the necessary records and to promote accurate responses. Such discussions are especially useful when such requests appear to be large, to be vague or confusing, seek information that does not exist as requested, or present other challenges that could impact response times. LDH and MCOs shall utilize these Protocols to produce streamlined, accurate and timely responses to PRRs.

Receipt of Potential Public Records Request

When LDH receives a request that may be a PRR, the Department will initiate contact with the MCO(s) that may have documents potentially responsive to the request. This will provoke a dialogue between the LDH legal team and MCO legal representatives where questions concerning the Request and potential responses can be addressed. The Parties agree to early and frequent communications regarding PRRs. These discussions would also allow for questions as to whether the document being sought may in fact be a public record.

Public Records' Requests Points of Contact for LDH and MCOs

The MCO shall provide LDH with the name of the individual who will serve as the point of contact for handling public records' requests within seven calendar days of request. If this point of contact changes at any time, the MCO shall provide LDH with an updated contact immediately.

LDH's point of contact for handling MCO-related public records' requests is the Medicaid Public Records Request Coordinator.

Transmission of the Public Records Request

Upon receipt of a PRR, LDH will determine if the response requires records from the MCO. If LDH believes the MCO has records responsive to a PRR, LDH shall notify the MCO of the PRR, and shall forward an exact copy of the request in its entirety via email to the MCO's point of contact for handling public records' requests within one business day of receipt.

If the MCO receives a public records' request directly from a requesting party, the MCO shall forward the request via email to the Medicaid Public Records Request Coordinator within one business day of receipt.

In no event shall the MCO directly respond to the requesting party to satisfy a PRR. Unless otherwise directed by a court of competent jurisdiction, LDH is the party that shall provide the response to each PRR.

If the MCO believes the records are not public and/or meet an exception to the Louisiana Public Records law, the MCO shall produce a log that describes each document or document type that is being withheld and shall describe the specific objection and legal basis for the withholding, pursuant to the timeline and in the requested format established by LDH. LDH and MCO agree that the MCO is only obligated to provide documents responsive to its Medicaid Managed Care product.

Process for LDH to Evaluate Whether Records are Subject to the Louisiana Public Records law

Upon receipt of objection from MCOs, LDH and MCO shall confer at a mutually convenient time with due consideration to legal restraints for compliance with Public Records Law. LDH Legal will review the objections, and confer with the Medicaid Public Records Request Coordinator, as necessary, to address MCOs objections. LDH and MCO will confer regarding response to the PRR, including production of documents for which no objection is made, and alternative response, if possible, for records (e.g., redaction) for which objection is made.

Notice to MCOs of Impending Release of Records MCO has Deemed Not Public and/or Meet an Exception to the Public Records Law

If LDH and MCO cannot agree to the response to the PRR, LDH will provide MCO with written notice that LDH will respond to the PRR over MCO's objections, specifying the date on which LDH will respond, which shall not be less than seven business days from the written notice. MCO has the right to seek injunctive or other judicial or administrative relief to prohibit LDH's response. If MCO elects to file a Petition for Injunctive Relief, Declaratory Judgment or other process for judicial or administrative relief, MCO will promptly deliver a copy of the petition or other pleading to LDH, and thereafter shall keep LDH notified of any significant developments that would impact LDH's obligations under Public Records laws. LDH and MCO shall cooperate as necessary any such judicial or administrative proceeding, and shall comply with the final judgment or other ruling or determination regarding PRR. If MCO does not file a Petition for Injunctive Relief or seek such judicial or administrative relief as specified above, LDH may respond to the PRR in the manner LDH determines appropriate.

PART 3: ELIGIBILITY & ENROLLMENT

The Louisiana Medicaid managed care program is comprised of mandatory and voluntary opt-in populations. LDH is responsible for determining eligibility for enrollment in the MCO, and the MCO is required to accept these enrollees for the provision of covered services.

The Contract identifies the populations that are eligible for enrollment in managed care and the service offerings available to them. This Manual broadly refers to enrollees with P-linkages and B-linkages.

***P-linkage**: Refers to enrollment in an MCO for physical health, behavioral health, and transportation services.*

***B-linkage**: Refers to enrollment in an MCO for specialized behavioral health and non-emergency medical transportation (NEMT), including non-emergency ambulance transportation (NEAT).*

Additional guidance regarding special populations and enrollment processes are provided in this section.

CERTIFICATE OF CREDITABLE COVERAGE

Certificates of Creditable Coverage, or portability letters, are written certificates issued by a health plan or health insurance issuer to show prior healthcare coverage. LDH determines the eligibility of individuals for enrollment into an MCO; therefore, the MCO shall direct any requests for a Certificate of Creditable Coverage to LDH.

The MCO should route enrollees to the Medicaid Recovery and Premium Assistance Unit at 225-342-8662 to request the certificate.

NEWBORN ENROLLMENT

A woman whose basis of Medicaid eligibility is pregnancy (LaMOMS) is a mandatory enrollee in the managed care program. When a pregnant woman chooses an MCO, she will be advised by the enrollment broker that her newborn will be enrolled in that same MCO for, at a minimum, the month of birth.

Following birth, the mother has the option to choose a different MCO for her baby. When this happens, enrollment in the new MCO will be effective the first day of the month after she chooses the new MCO if the choice is made on or before the second to last working day of the month.

Hospitals will continue to report births to LDH via the Newborn Request Form via the web-based facility notification system. Within three business days, LDH will assign the newborn a Medicaid ID number and add the baby to the Medicaid eligibility file. On the night that the newborn is added to the Medicaid eligibility file, the enrollee information will be sent to the enrollment broker. The enrollment broker will include the newborn on the next daily enrollment file to the mother's MCO and the MCO will add the newborn to their enrollee file. Enrollment of newborns shall be retroactive to the date of the birth.

The enrollment broker will generate a confirmation letter to the mother indicating that the baby has been enrolled in the MCO in which she is enrolled and giving her 90 days from the date of the letter to select a different MCO for the baby if she chooses to do so.

The MCO is responsible for covering all newborn care rendered within the first month of life regardless of whether it is provided by in an in-network or out-of-network provider.

NOTE: Primary care physician (PCP) assignment for the newborn is made by the MCO, not by LDH or the enrollment broker. Refer to the Contract for requirements.

ELIGIBILITY UPDATES

The enrollment broker shall make available to the MCO, via electronic media (i.e., ASC X12N 834 Benefit Enrollment and Maintenance transaction), daily updates on new enrollees in the format specified in the **834 Systems Companion Guide**.

In addition to the daily file, the enrollment broker shall transmit to the MCO files containing retroactive updates to enrollment. These files will be available to download via the enrollment broker's EDI site.

Medicaid Eligibility Determinations Based on SSI

When Supplemental Security Income (SSI) determinations are obtained by LDH from the Social Security Administration, they may be retroactive and LDH will alter eligibility periods with the appropriate aid category/type case information. This eligibility process may cause overlaps with existing eligibility periods for the impacted enrollees, resulting in a need for reconciliation between LDH, the fiscal intermediary, the enrollment broker, and the MCO.

The overlapping certification will be transmitted daily from LaMEDS to the fiscal intermediary. The fiscal intermediary will send the overlapping eligibility information to the enrollment broker via daily enrollee files and/or weekly full reconciliation files, and the enrollment broker will distribute to the MCOs via 834 full reconciliation file in the 2700 Loop. All historical eligibility will be present on the file.

The fiscal intermediary will conduct a retrospective SSI cleanup on a monthly basis, with a 12-month look back period from the beginning of the month. MCOs can identify impacted enrollees by reviewing the associated 820 file.

ADMINISTRATIVE RETROACTIVE CORRECTIONS

Administrative retroactive corrections to enrollee linkages may be necessary to ensure compliance with internal policies and the approved Louisiana Medicaid State Plan. These corrections may address multiple months and significantly impact paid claims and PMPMs.

Each month, LDH and its fiscal intermediary will review all changes made by the enrollment broker in the prior month to identify retroactively enrolled or disenrolled individuals, claims paid within this retroactive period, and associated adjustments needed to PMPMs.

LDH, or its designee, will send a monthly report of impacted enrollees to the MCOs with detailed information to assist in anticipating claims which should be billed to them for their retroactively enrolled enrollees.

Retroactive Enrollment

An enrollee may be retroactively enrolled with an MCO up to 12 months prior to the enrollee's MCO linkage add date. Providers have up to 365 calendar days from the date of service or 180 calendar days from the enrollee's MCO linkage add date, whichever is later, to submit claims to the MCO for dates of service during the retrospective enrollment period. The MCO linkage add date is reported on the 834 file header.

MCOs shall not deny these claims for timely filing, prior authorization or precertification edits. The provider shall not be required to submit the enrollee's eligibility determination award letter. Instead, the MCO shall develop a process to bypass timely filing, prior authorization, and precertification edits using the enrollee's MCO linkage add date.

MCOs may conduct post-service reviews for medical necessity, and if the MCO determines the service was not medically necessary, the MCO may deny the claim. The provider will have the right to appeal the denial.

Retroactive Disenrollment

The MCO shall review the daily 834 files and any manual special processing files provided by the enrollment broker on a daily basis to identify whether any of its enrollees were retroactively disenrolled. The MCO shall identify all associated claims which were paid for these enrollees.

If the enrollee was retroactively disenrolled *due to the invalidation of a duplicate Medicaid ID and the remaining valid ID is linked to another MCO*, in accordance with the Contract, the MCO shall subrogate the amount of the paid claims to the MCO that paid the claims for the dates of service.

If the enrollee was retroactively disenrolled for any other reason, the MCO shall:

- Initiate recoupments of reimbursements to providers, via written notice, within 60 days of the date LDH notifies the MCO of the change.
- Require providers to submit paper/hard copy claims to the correct entity, unless the MCO has established other means of identifying these claims.
    - Providers shall not be required to obtain prior authorization or pre-certification for these claims.
    - Providers must attach documentation supporting the void. This may be the remittance advice (RA) indicating the void.
    - The MCO shall not deny claims submitted in cases of retroactive eligibility for timely filing if the claim is submitted within 180 days from the enrollee's linkage to the MCO.
        - The exception to the retroactive eligibility timely filing requirements are such that the claim must be submitted to the MCO by the latter of 365 calendar days from the date of service or 180 days from the enrollee's linkage to the MCO.
- Submit encounters for voided claims to the fiscal intermediary.

Refer to the Contract for additional requirements related to provider recoupments, including provider notification requirements.

ENROLLEE RETROACTIVE REIMBURSEMENT

The MCO is responsible for processing retroactive reimbursement requests submitted by Medicaid enrollees. Medicaid enrollees may be directly reimbursed for part or all of any medical expenses paid by them to any Medicaid provider for medical care, services, and supplies delivered during the period of retroactive eligibility and prior to the expected date of receipt of the MCO's ID card and/or expected date of receipt of notification of linkage to the MCO. Value-added benefits offered by the MCOs are not eligible for reimbursement.

The MCO must have written policies and procedures for receiving, processing, and issuing payment for enrollee retroactive reimbursement requests and a tracking system that can be accessed by its member services staff.

The MCO shall provide customer service to enrollees who seek explanations and/or education regarding retroactive reimbursement issues.

The MCO must use claims payment business processes that deny or approve requests for retroactive reimbursement. For approved requests, the business processes must be able to do the following: edit, adjudicate, adjust, void, pay, and audit the request for reimbursement of covered Medicaid services. In cases of a retroactive reimbursement involving third party liability, the MCO may instruct the provider to resubmit the unpaid portion of the claims to the MCO for payment, if applicable.

MCOs must provide written notice of eligibility for retroactive reimbursement information in an enrollee welcome letter. The welcome letter must include the following policies and provide the date the request is due:

- Enrollees are eligible for reimbursement of medical expenses paid three months prior to the month of application if they requested retroactive coverage on their application and received approval.
- Enrollees are given 30 calendar days from the date of the welcome letter to contact the MCO to request consideration for reimbursement and provide the required documentation.
- An extension of up to 10 calendar days shall be granted if the extension is requested on or before the deadline. A second extension of no more than 10 additional calendar days should be granted if the extension is requested before the deadline of the first extension. No extensions shall be granted beyond this timeframe.

Changes to existing documents (e.g., policies, welcome letter templates) must be reviewed and approved by LDH in advance.

Reimbursement Criteria

Reimbursement shall be provided only under the following conditions:

- The enrollee is Medicaid eligible for the date of service.
- The MCO has verified that the provider is enrolled with the MCO on the date on which the enrollee received the service and is approved to provide the service rendered.
- The bills must be for services received on or after the Medicaid effective date through receipt of the initial Medicaid eligibility card (MEC) or reactivation of the MEC. Reactivation of the MEC would take place when an enrollee of Medicaid status has an interruption in coverage, reapplies and is certified for coverage in a qualifying Medicaid program. The certification period is usually twelve months.

- The enrollee has not received reimbursement from Medicaid or the Medicaid provider or received payment in full by a third-party entity.
- The medical bills must be for medical care, services, or supplies covered by Medicaid at the time that the service was delivered.
- The enrollee must provide proof of payment to the MCO. Bills which were paid in full by a third party (e.g., Medicare, an insurance company, charitable organization, family, or friend) cannot be considered for reimbursement unless the enrollee remains liable to the third party. It is a requirement that continuing liability of the enrollee be verified.

Bills Not Eligible for Reimbursement

- Unpaid bills - the enrollee should present his or her MEC to the provider along with the unpaid bill so that the provider can file a claim.
- Bills paid by the enrollee after receipt of the initial MEC or reactivation of the MEC.
- Bills paid to a non-Medicaid provider who does not participate in the Medicaid Program.
- DME purchased without documentation of medical necessity.
- Over-the-counter medications or supplies purchased without a prescription.
- Value-added benefits offered by the MCO.

Reimbursements Involving Third Party Liability

The MCO should use a cost comparison method for enrollee reimbursement requests involving third-party liability (TPL). The claim must first be processed by the primary payer. The TPL payment amount is provided on the explanation of benefits (EOB) sent by the primary payer. The reimbursement to the enrollee shall be the Medicaid allowed amount minus the TPL payment. If the TPL payment is greater than the Medicaid allowed amount, the reimbursement to the enrollee would be zero.

The MCO shall require enrollees to submit all of the required documentation listed below within the timeframes specified above.

Required Documentation

An enrollee seeking reimbursement must provide to the MCO a copy of the bill(s) or other acceptable verification which include(s) the following:

- Name of the individual who received the service,
- Name, address and phone number of the physician or facility providing the service,
- Date of service,
- Procedure and Diagnosis codes,
- Amount of billed charges and verification of payment,
- Receipts or other acceptable proof showing that the bill was paid by the Medicaid enrollee or someone else. If paid by someone else, proof that the eligible is still liable for repayment to the individual who paid the bill,
- Proof of payment by any Private Insurance - EOB, and, **if applicable**,

- If Durable Medical Equipment (DME) - dates of service, quantity, diagnosis and procedure codes, documentation of medical necessity from the provider, amount billed, amount enrollee paid, and verification of private insurance payments (EOB).
- If Dental - diagnosis and procedure codes per tooth.
- If Pharmacy - date prescription was filled, National Drug Code (NDC), quantity dispensed, and retail cash price if insurance or discount card was used or the amount paid by the third-party entity.

If the MCO determines that additional information is needed from the enrollee, the MCO shall mail a Recipient Verification Request Form to the enrollee within three business days of the receipt of the initial request.

The enrollee shall be allowed 15 days to provide the additional documentation and, upon request for additional time, be granted an extension. If an extension is requested, no more than 15 additional days shall be granted. Enrollees who fail to provide the requested documentation or fail to request an extension shall have the request for reimbursement denied.

Processing Timeframes

MCOs must follow established timeframes as required by the Contract. A reimbursement request is considered clean when the enrollee has timely submitted all requested documentation within the established timeframe; therefore, the MCO shall process the request within three months from the date of the request and mail a Notice of Decision Letter to the enrollee. If the request is denied, the notice must include a clear explanation of the reason(s) for ineligibility for reimbursement.

Requests received by the MCOs for reimbursement of payment for carved-out services must be submitted to LDH within five business days of receipt for processing by LDH.

Managed Care Linkage for Long Term Care Enrollees

A managed care enrollee with a P-linkage who is subsequently certified in long term care (LTC) will be disenrolled from the P-linkage effective the last day of the month during which the enrollee is admitted to the nursing facility. As eligibility dictates, the enrollee will be enrolled in a B-linkage effective the first day of the month following the enrollee's LTC certification.

This will provide continuity of care for enrollee's transitioning from post-acute skilled nursing facility rehabilitative care into LTC. This will also stabilize claims and reimbursement responsibilities.

Claims Responsibility

During the single transitional month where an enrollee is both in a P-linkage and certified in LTC, the MCO remains responsible for all managed care physical and behavioral health services that are not the responsibility of the nursing facility.

MCOs must have appropriate edits in place to ensure that they are not reimbursing the nursing facility for post-acute skilled nursing services under their "in lieu of" authority after the LTC certification begins.

The MCO will receive the LTC begin and end date and the nursing facility admit and discharge date on the 834 file (loop 2300 at HD03).

Medicaid fee-for-service (FFS) will maintain responsibility for nursing facility charges for LTC certified members (i.e., after the LTC begin date). The nursing facility, as provided for in the Louisiana Administrative Code, Title 50, Public Health - Medical Assistance, will be responsible for billing nursing facility covered services to FFS.

MCOs shall ensure that physician services are not reimbursed by the MCO after the LTC begin date as these are paid for in the per diem reimbursed by Medicaid FFS. Specifically, excluded physician services after the LTC certification begins include, but are not limited to, the following:

- Physician claims (claim type 04) for Personal Care Services (type of service is 10, procedure code is T1019 with a '"UB," "UN" or "UP" modifier) for an enrollee that is linked to a LTC facility as of the date of service.
- Physician, Professional Crossover, or DME claims (claim type 04, 09 or 15) for a primary surgical dressing kit (procedure code is A4555) for an enrollee that is linked to a LTC facility as of the date of service.
- Physician claims (claim type 04) for medication monitoring or administration (procedure codes H0033, H0034, T1502, T1503) for an enrollee that is linked to a SNF, ICF-I, ICF-II or Community Hospice LTC facility (level of care is 20, 21, 22 or 88) as of the date of service.
- Physician claims (claim type 04) for therapy, evaluation or consultation services (procedure codes 97597, 97598, 97602, 97605-97608, 97610, 97113, 97161-97164, 97165-97168, 97169-97172, 92521-92522, 92523, 92524, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 92526, 97010, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032-97039, 97760-97762, 97764, 97799, 97082-97084, 98925-98929, 98941-98943, G0151, G0152, G0153, G0155, G0156, G0157, G0158, G0159, G0160, G0161, G0162) for an enrollee that is linked to an ICF/IID LTC facility (level of care is 26, 41, 42, 43 or 44) as of the date of service.
- Physician claims (claim type 04) for certain first aid supplies (procedure codes A4244, A4246, A4204, A4454, A4200, A4202, A4205, A4555, A4357, A5114, B4081) for an enrollee that is linked to a LTC facility that is not an Adult Day Care (level of care is not 27) as of the date of service.

Disenrollment Notification

P-linkage disenrollment information and B-linkage enrollment will be transmitted to the MCO in the daily 834 file with disenrollment codes 931 and 932.

- Code 931 example:
  - Enrollee has an 8/1/2017 plan start date with a P-linkage.
  - Enrollee was certified in LTC with a 7/2/2017 date of admission.
  - Code 931 will be used to void the 8/1/2017 plan start date and transfer the enrollee into B-linkage with an 8/1/2017 plan start date.
- Code 932 example:
  - Enrollee has a 2/1/2016 plan start date with a P-linkage.
  - Enrollee was certified in LTC with an 8/2/2017 date of admission.
  - Code 932 will be used to close the 2/1/2016 plan start date with an 8/31/2017 end date and transfer the enrollee into B-linkage with a 9/1/2017 plan start date.

PART 4: SERVICES

The Louisiana Medicaid State Plan establishes the services covered as well as reimbursement methodologies for Medicaid FFS. State Plan services are broad categories (e.g., physician services, hospital services), and the Medicaid FFS fee schedule operationalizes that coverage. In accordance with 42 C.F.R. §438.210, the MCO must provide for coverage of services that is no more restrictive in amount, scope, and duration than is covered in Medicaid FFS.

Compared with Medicaid FFS, the MCO has the flexibility to cover services in a *greater* amount, scope, or duration, or to an *expanded* patient group, if deemed medically necessary. Nothing herein shall be construed by the MCO to limit coverage to only those procedure codes listed on the Medicaid FFS fee schedules. Within the broad State Plan categories, the MCO has the flexibility to reimburse for procedure codes not on the Medicaid FFS fee schedules when medically necessary. For those services not covered under the State Plan, the Contract identifies requirements for in-lieu-of services and value-added benefits that the MCO may offer. The MCO shall consult LDH with any questions about these requirements.

Further, federal law mandates that enrollees under 21 years of age are entitled to receive all medically necessary health care, screening, diagnostic services, treatment, and other measures to correct or improve physical or mental conditions (Section 1905(r) of the Social Security Act). The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is comprehensive in nature and includes coverage of all services described in federal Medicaid statutes and regulations including those that are not covered for adults, not explicitly described in the Contract, not included in the Medicaid FFS fee schedules, and not covered in the Louisiana Medicaid State Plan. The MCO shall consult LDH with any questions about these requirements.

This section defines minimum coverage and reimbursement policies for select services only and does not represent an exclusive list of covered services. Unless otherwise agreed to by the MCO and its contracted providers, the Medicaid FFS fee schedule establishes the minimum reimbursement rates for services rendered to enrollees. Any references herein to a minimum reimbursement rate shall include the exception that the MCO may contract with its providers to reimburse the service at a lower rate, if the contracting parties agree.

The MCO shall develop and maintain comprehensive provider manuals customized to the Louisiana Medicaid managed care program that are in alignment with this Manual and inclusive of all applicable MCO-established policies. The MCO shall not include references to the **Medicaid Services Manual** or this Manual in lieu of maintaining its own comprehensive provider manuals. The MCO shall make coverage decisions in alignment with its own provider manuals, with the policies in this section, and with the Contract.

The MCO shall update its provider manuals in a timely manner and be responsive to provider questions or concerns.

MCO Covered Services

Services for which LDH has established specific minimum coverage and reimbursement policies are noted below with an asterisk (*) when included in this Manual. Outside of this Manual, certain services for which LDH has established minimum coverage and reimbursement policies are located in the **Medicaid Services Manual**, as notated below. Policies for in-lieu of services and value-added benefits are not included in this section.

- Physical Health Services
  - Allergy Testing and Allergen Immunotherapy*
  - Ambulatory Surgical Services*
  - Anesthesia*
  - Applied Behavior Analysis Therapy (age 0-20) (Refer to **Medicaid Services Manual,** Applied Behavior Analysis)
  - Audiology Services
  - Bariatric Surgery*
  - Breast Surgery*
  - Chiropractic Services* (age 0-20)
  - Cochlear Implant* (age 0-20)
  - Diabetes Self-Management Training*
  - Durable Medical Equipment, Prosthetics, Orthotics and Certain Supplies (Refer to **Medicaid Services Manual,** Durable Medical Equipment)
  - Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Services* (age 0-20)
  - Emergency Services*
  - End Stage Renal Disease Services (Refer to **Medicaid Services Manual**, End Stage Renal Disease)
  - Eye Care and Vision Services*
  - Family Planning Services*
  - Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Services (Refer to **Medicaid Services Manual**, Federally Qualified Health Centers, Rural Health Clinics)
  - Genetic Testing*
  - Glasses, Contacts, and Eye-Wear (Refer to **Medicaid Services Manual**, Vision)
  - Gynecology*
  - Home Health-Extended Services (age 0-20) (Refer to **Medicaid Services Manual**, Home Health)
  - Home Health Services*
  - Hospice Services (Refer to **Medicaid Services Manual**, Hospice)
  - Hospital Services*
    - Inpatient Hospital Services*
    - Outpatient Hospital Services*
  - Hyperbaric Oxygen Therapy*
  - Immunizations*
  - Intrathecal Baclofen Therapy*
  - Laboratory and Radiology Services*
  - Limited Abortion Services*
  - Medical Transportation Services*
  - Newborn Care and Discharge*
  - Obstetrics*
  - Pediatric Day Healthcare Services (age 0-20) (Refer to **Medicaid Services Manual**, Pediatric Day Health Care)
  - Personal Care Services* (age 0-20) (Refer to **Medicaid Services Manual**, Personal Care Services. Refer to this Manual for policies specific to EVV.)
  - Pharmacy Services*
  - Physician Administered Medication*

- Physician/Professional Services*
- Podiatry Services
- Preventive Services for Adults* (age 21 and older)
- Sterilization*
- Telemedicine/Telehealth*
- Therapy Services*
- Tobacco Cessation Services
- Vagus Nerve Stimulators*

❖ Behavioral Health Services
- Basic Behavioral Health Services*: Services provided through primary care, including, but not limited to, screening for mental health and substance use issues, prevention, early intervention, medication management, and treatment and referral to specialty services.
- Specialized Behavioral Health Services (Refer to the Behavioral Health Services Provider Manual chapter of the **Medicaid Services Manual** and its appendices for all specialized behavioral health services.)
  - Licensed Practitioner Outpatient Therapy
    - Parent-Child Interaction Therapy (PCIT)
    - Child Parent Psychotherapy (CPP)
    - Preschool PTSD Treatment (PPT) and Youth PTSD Treatment (YPT)
    - Triple P Positive Parenting Program
    - Trauma-Focused Cognitive Behavioral Therapy
    - EMDR Therapy
  - Mental Health Rehabilitation Services
    - Community Psychiatric Support and Treatment (CPST)
      - Multi-Systemic Therapy (MST) (age 0-20)
      - Functional Family Therapy (FFT) and Functional Family Therapy-Child Welfare (age 0-20)
      - Homebuilders® (age 0-20)
      - Assertive Community Treatment (age 18 and older)
    - Psychosocial Rehabilitation (PSR)
    - Crisis Intervention
    - Crisis Stabilization (age 0-20)
  - Therapeutic Group Homes (TGH) (age 0-20)
  - Psychiatric Residential Treatment Facilities (PRTF) (age 0-20)
  - Inpatient Hospitalization (age 0-21; 65 and older)
  - Outpatient and Residential Substance Use Disorder Services
  - Medication Assisted Treatment

Out-of-State Medical Care

The MCO shall cover medically necessary services to enrollees provided outside of the state when any of the following conditions are met:

❖ Medical services are needed because of a medical emergency;

- ❖ Medical services are needed and the enrollee's health would be endangered if the enrollee were required to travel to the enrollee's state of residence;
- ❖ The MCO determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state; or
- ❖ It is general practice for enrollees in a particular locality to use medical resources in another state.

The MCO shall prior authorize all non-emergency out-of-state care.

PROHIBITED AND NON-COVERED SERVICES

The MCO shall ensure that physicians and all other professionals abide by the professional guidelines set forth by their certifying and licensing agencies in addition to complying with Louisiana Medicaid regulations.

In general, services that are not approved by the Food and Drug Administration or services that are experimental, investigational, or cosmetic are excluded from Medicaid coverage and will be deemed not medically necessary.

The following non-exhaustive list of services excluded from MCO covered services and/or otherwise limited by Louisiana Medicaid shall be reflected in the MCO's coverage policy:

- ❖ Any service (drug, device, procedure, or equipment) that is not medically necessary;
- ❖ Experimental/investigational drugs, devices, procedures, or equipment, unless approved by the Secretary of LDH;
- ❖ Cosmetic drugs, devices, procedures, or equipment;
- ❖ Assistive reproductive technology for treatment of infertility;
- ❖ Elective abortions (those not covered in the Louisiana Medicaid State Plan) and related services;
- ❖ Surgical procedures discontinued before completion;
- ❖ Harvesting of organs when a Louisiana Medicaid enrollee is the donor of an organ to a non-Medicaid enrollee; and
- ❖ Provider preventable conditions, described below.

Provider Preventable Conditions

Louisiana Medicaid is mandated to meet the requirements of 42 C.F.R. §447.26 with respect to non-payment for provider preventable conditions (PPCs). The MCO is required to implement procedures for non-payment for these events when applicable to its enrollees.

PPCs are defined into two separate categories:

- ❖ Health care-acquired condition (HCAC), meaning a condition occurring in any inpatient hospital setting, identified as a hospital acquired condition (HAC) in accordance with 42 C.F.R. §447.26; and
- ❖ Other provider preventable condition (OPPC), meaning a condition occurring in any health care setting in accordance with 42 C.F.R. §447.26.

The MCO shall not impose a reduction in reimbursement for a PPC when the condition defined as a PPC for a particular enrollee existed prior to the initiation of treatment for the enrollee by that provider.

Reductions in provider reimbursement may be limited to the extent that the following apply:

- ❖ The identified PPCs would otherwise result in an increase in reimbursement.
- ❖ It is practical to isolate for non-payment the portion of the reimbursement directly related to treatment for, and related to, the PPC.

Non-payment of PPCs shall not prevent access to services for Medicaid enrollees.

Health Care-Acquired Conditions

Refer to the CMS website for the current listing of HACs and associated diagnoses [link].

NOTE: Louisiana Medicaid considers HACs as identified by Medicare, other than deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

It is the responsibility of the MCO to determine if the HCAC was the cause for any additional days added to the length of stay. The MCO may not reimburse for services related to HCAC.

Medicaid will require the Present-on-Admission (POA) indicators as listed below with all reported diagnosis codes. POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation or outpatient surgery, are considered as present on admission.

Present on Admission Reporting Options:

Code	Definition
Y	Present at the time of inpatient admission
N	Not present at the time of inpatient admission
U	Documentation is insufficient to determine if condition is present on admission
W	Provider is unable to clinically determine whether condition was present on admission or not

Refer to the CMS website for the current listing of diagnoses that are exempt from POA reporting requirements [link].

Other Provider Preventable Conditions

MCOs are prohibited from reimbursing providers for the following OPPCs in any setting:

- ❖ Wrong surgical or other invasive procedure performed on a patient;
- ❖ Surgical or other invasive procedure performed on the wrong body part; or
- ❖ Surgical or other invasive procedure performed on the wrong patient.

The MCO shall not reimburse for any days that are attributable to the OPPC. The diagnosis codes that are utilized for the three OPPCs listed above are included below.

- ❖ Y65.51 — Performance of wrong operation (procedure) on correct patient (existing code)
- ❖ Y65.52 — Performance of operation (procedure) on patient not scheduled for surgery
- ❖ Y65.53 — Performance of correct operation (procedure) on wrong side/body part

Outpatient Hospital Claims

In the event an outpatient surgery is performed erroneously, as described below, the appropriate modifiers to all lines related to the erroneous surgery/procedure are:

- PC: Wrong Surgery on Patient;
- PB: Surgery Wrong Patient; or
- PA: Surgery Wrong Body Part;

In summary, it is the responsibility of the provider to identify and report (through the UB-04) any PPC and not seek reimbursement from Medicaid for any additional expenses incurred as a result of the PPC. The MCO may disallow or reduce provider reimbursements based on a post-payment review of the medical record.

It is the responsibility of the MCO to ensure that reimbursement is not made for any expense as a result of a PPC.

AMBULATORY SURGICAL SERVICES

The MCO shall cover ambulatory surgical services, defined as surgical services where patients do not require hospitalization and in which the expected duration of services would not exceed 24 hours. Ambulatory surgical services can be provided in non-hospital ambulatory surgical centers and outpatient hospitals.

Ambulatory Surgical Centers (Non-Hospital)

Covered Services

The MCO shall cover medically necessary, preventive, diagnostic, therapeutic, rehabilitative or palliative services furnished to an outpatient by or under the direction of a physician or dentist in a free-standing facility which is not part of a hospital but which is organized and operated to provide medical care to enrollees.

ASC services are items and services furnished by an outpatient ASC in connection with a covered surgical procedure. Covered services include, but are not limited to the following:

- Nursing, technician, and related services;
- Use of an ambulatory surgical center;
- Lab and radiology, drugs, biologicals, surgical dressings, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure;
- Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
- Administrative, record keeping, and housekeeping items and services;
- Materials for anesthesia;
- Intraocular lenses; and
- Supervision of the services of an anesthetist by the operating provider.

Exclusions

ASC services do not include items and services for which reimbursement may be made under other, separate, programs. ASC services do not include:

- Professional services;
- Lab and radiology services not directly related to the surgical procedure;
- Diagnostic procedures (other than those directly related to performance of the surgical procedure);
- Prosthetic devices (except intraocular lens implants);
- Ambulance services;
- Leg, arm, back, and neck braces;
- Artificial limbs; and
- Durable medical equipment for use in the enrollee's home.

Provider Requirements

The MCO shall ensure that ASCs have an agreement with the Centers for Medicare and Medicaid Services (CMS) in accordance with 42 C.F.R. §416.30 and that ASCs are licensed and certified by Louisiana's licensing and certification agency.

The MCO's policy shall include the directive that the ASC must have a system to transfer enrollees requiring emergency admittance or overnight care to a fully licensed and certified hospital following any surgical procedure performed at the facility.

Reimbursement

The MCO shall reimburse ASCs a flat fee per service. The minimum reimbursement shall be in accordance with the four payment groups specified in the Louisiana Medicaid Ambulatory Surgical Centers (Non-Hospital) Fee Schedule.

The flat fee reimbursement is for facility charges only, which covers all operative functions associated with the performance of a medically necessary surgery while the enrollee is in the center including the following:

- Admission;
- Patient history and physical;
- Laboratory tests;
- Operating room staffing;
- Recovery room charges; and
- All supplies related to the surgical care of the enrollee and discharge.

The flat fee excludes reimbursements for professional services (e.g., the provider performing the surgery, dentists, anesthesiologists, radiologists, or osteopaths).

For those surgical procedures not included in the payment groupings, the minimum reimbursement is the flat fee for the service specified on the Louisiana Medicaid Ambulatory Surgical Centers (Non-Hospital) Fee Schedule.

Only one procedure code may be reimbursed per outpatient surgical session.

Outpatient Hospital Ambulatory Surgery

The MCO shall cover certain ambulatory surgical procedures if they are performed in the outpatient hospital setting. The MCO shall reimburse hospitals for the performance of these outpatient surgical procedures on a flat-fee per service basis.

The MCO shall require hospitals to bill all outpatient surgery charges for the specified surgeries using revenue code "490" — Ambulatory Surgery Care. All other charges associated with the surgery (e.g., observation, labs, radiology) must be billed on the same claim as the ambulatory surgery charges. The only revenue code that will be paid will be the flat rate fee for the ambulatory surgery. The minimum reimbursement rate for groupings can be found on the Louisiana Medicaid Outpatient Hospital Ambulatory Surgery Fee Schedules. A list of the surgical procedures is also provided on the fee schedule.

For minor surgeries that are medically necessary to be performed in the hospital operating room but the associated CPT code is not included in the Louisiana Medicaid Outpatient Hospital Ambulatory Surgery Fee Schedules, the MCO shall require hospitals to bill using revenue code HR361 - Operating Room Services-Minor Surgery.

When more than one surgical procedure is performed on the same date of service, the MCO shall pay only the primary surgical procedure.

BEHAVIORAL HEALTH SERVICES

Basic behavioral health services are mental health and substance use services which are provided to enrollees with emotional, psychological, substance use, psychiatric symptoms and/or disorders that are provided in the enrollee's primary care physician (PCP) office by the enrollee's PCP as part of primary care service activities.

Specialized behavioral health services are mental health services and substance use/addiction disorder services, specifically defined in the Louisiana Medicaid State Plan and/or applicable waivers. These services are administered under LDH authority in collaboration with the MCOs, as well as through the Coordinated System of Care (CSoC) program contractor, for CSoC enrollees. The MCO shall comply with the Behavioral Health Services Provider Manual chapter of the **Medicaid Services Manual**.

Emergency Certificates for Inpatient or Residential Behavioral Health Services

This section provides guidance relative to implementation of Act 390 of the 2015 Regular Legislative Session relative to reimbursement for inpatient/residential behavioral health services for persons admitted to treatment under an emergency certificate. Emergency certificates are inclusive of Physician's Emergency Certificates, Coroner's Emergency Certificates, and Judicial Certificates.

The MCO is required to pay claims for behavioral health services provided to enrollees committed under an emergency certificate to an inpatient or residential facility regardless of medical necessity. This payment requirement shall be for a maximum period of 24 hours from the time of admission to the inpatient or residential facility, as long as the following conditions are met:

- ❖ The admitting physician and the evaluating psychiatrist or medical psychologist shall offer the subject of the emergency certificate the opportunity for voluntary admission; and
- ❖ Any person committed under an emergency certificate shall be evaluated by a psychiatrist or medical psychologist in the admitting facility within 24 hours of arrival at the admitting facility.

After the psychiatric evaluation has been completed, payment of claims shall be determined by medical necessity. If the subject of the emergency certificate does not receive a psychiatric evaluation within the required timeframe, the MCO is only required to pay behavioral health claims within the first 24 hours of admission. Payment for any subsequent claim shall be determined by medical necessity.

Reimbursement under this Act is limited to behavioral health claims and usual and customary laboratory services necessary to monitor patient progress. The MCO is not responsible for payment of non-behavioral health service claims which fail to meet medical necessity criteria.

Refer to the following links for statutory requirements for admission by emergency certificate or judicial commitment and voluntary admission:

- ❖ Admission under emergency certificate [link]
- ❖ Judicial commitment [link]
- ❖ Formal voluntary admission [link]

Forms for emergency certificates, judicial commitments, and voluntary admissions are promulgated through the Office of Behavioral Health on the LDH website [link] as follows:

- ❖ OBH 1 – Physician's emergency certificate
- ❖ OBH 1A – Psychologist's emergency certificate
- ❖ OBH 2 – Coroner's emergency certificate
- ❖ OBH 11 – Petition for judicial commitment (hospital/facility)
- ❖ OHB 143 – Physician's certificate for minors
- ❖ OBH 7 - Formal voluntary admission

Pre-Admission Screening and Resident Review

All persons seeking admission to a Medicaid certified nursing home are required to complete a preadmission screen (PAS/Level I) prior to admission and send it to LDH's Office of Aging and Adult Services (OAAS). Those identified as suspected of having a mental illness are referred by OAAS to the Office of Behavioral Health (OBH)-Pre-Admission Screening and Resident Review (PASRR) for a Level II determination.

OBH-PASRR refers all enrollees for an independent evaluation to their respective MCO if a face-to-face evaluation was deemed necessary to determine the enrollee's need for nursing home admission and services. MCOs shall adhere to the contract requirements related to the staffing and implementation of the PASRR Level II evaluation process.

In accordance with PASRR operations, MCOs must submit the PASRR Level II evaluation to OBH-PASRR for a final determination. Complete and thorough Level II evaluations should be submitted to OBH-PASRR and should include the following information:

- A comprehensive history and physical that includes complete medical history; review of all bodily systems; specific evaluations of the person's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves and abnormal reflexes; and in the case of abnormal findings which are the basis of nursing home placement, additional evaluations conducted by appropriate specialists.
- A comprehensive drug history including current or immediate past use of medications that could mask symptoms or mimic mental illness, side effects or allergies.
- A psychosocial evaluation.
- A comprehensive psychiatric evaluation including a complete psychiatric history; evaluation of intellectual functioning, memory functioning and orientation; description of current attitudes and overt behaviors, affect, suicidal or homicidal ideation, paranoia and degree of reality testing (presence of content of delusions); and hallucinations.
- Records that speak to the reason for nursing home placement, including documentation to support categorical determinations (i.e., terminal illness, severe physical illness, or any illness where the individual is not likely to benefit from a specialized behavioral health service).
- If there is an indication of dementia within the records, include corroborative testing or other information available to verify the presence of progression of the dementia (i.e., dementia work up, Comprehensive Mental Status Exam).

MCOs should ensure the appropriate linkage of individuals referred through the PASRR Level II process to case management and services regardless of the final determination of placement into a nursing facility, in accordance with processes outlined within the **DOJ Compliance Guide**. Additionally, the MCOs shall maintain appropriate records and utilize the LDH-identified templates.

HOSPITAL SERVICES

A hospital is defined as any institution, place, building, or agency, public or private, whether for profit or not, maintaining and operating facilities, 24-hours a day, seven days a week, having 10 licensed beds or more. The hospital must be properly staffed and equipped for the diagnosis, treatment and care of persons admitted for overnight stay or longer who are suffering from illness, injury, infirmity, or deformity or other physical or mental conditions for which medical, surgical, and/or obstetrical services would be available and appropriate.

An inpatient or outpatient hospital may be the service location for many of the services that are described within the *Services* section of this Manual. Unless otherwise detailed within the *Hospital Services* subsection, the MCO shall refer to the guidelines and requirements for those specific services as provided within this Manual.

The MCO must ensure that hospitals participating in its network meet all applicable certification and licensing requirements issued by the state in which they are located. The LDH Health Standards Section (HSS) is the only licensing authority for hospitals in the state of Louisiana.

As described in the Contract, the MCO's rate of reimbursement shall be no less than the published Medicaid FFS rate in effect on the date of service or that is contained on the weekly procedure file sent to the MCO by the fiscal intermediary, or its equivalent, unless mutually agreed to by both the MCO and the provider in the provider agreement.

General Policies

Inpatient vs. Outpatient Services

- The MCO must ensure that inpatient services are not reimbursed as outpatient, even if the stay is less than 24 hours. Federal regulations are specific in regard to the definition of both inpatient and outpatient services. The following requirements apply:
  - All outpatient services except outpatient therapy performed within 24 hours of an inpatient admission shall be included on the inpatient claim.
  - All outpatient services except outpatient therapy performed within 24 hours before an inpatient admission and 24 hours after the discharge shall be included on the inpatient claim. This includes outpatient services that are either related or unrelated to the inpatient stay.
  - If an inpatient in one hospital has outpatient services performed at another hospital, the inpatient hospital is responsible for reimbursing the hospital providing the outpatient services. The inpatient hospital may reflect the outpatient charges on its claim.
- If an enrollee is treated in the emergency room and requires surgery, which cannot be performed for several hours because arrangements need to be made, the services may be billed as outpatient provided the enrollee is not admitted as an inpatient.
- Physicians responsible for an enrollee's care at the hospital are responsible for deciding whether the enrollee is to be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for enrollees who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment, which can be made only after the physician has considered a number of factors. Admissions of particular enrollees are not covered or non-covered solely on the basis of the length of time the enrollee actually spends in the hospital.
- The MCO will reimburse up to 48 hours when medically necessary for an enrollee to be in an outpatient status. This time frame is for the physician to observe the enrollee and to determine the need for further treatment, admission to an inpatient status or for discharge. If the enrollee is admitted as an inpatient, the admit date will go back to the beginning of the outpatient services.

Discharge Clarification

The MCO shall consider an inpatient or outpatient to be discharged from the hospital and paid under the prospective payment system (PPS) when:

- The enrollee is formally discharged from the hospital; or
- The enrollee dies in the hospital.

Non-medically necessary circumstances are not considered in determining the discharge time; therefore, the MCO shall not reimburse hospitals under these circumstances (e.g., enrollee does not have a ride home, does not want to leave, etc.).

If non-medical circumstances arise and cause the enrollee to stay in the hospital after he/she is discharged, and the hospital is not reimbursed for the post-discharge portion of the stay, the enrollee may be billed but only after hospital personnel have informed him/her that Medicaid will not cover that portion of the stay.

If the enrollee is readmitted to a different hospital than the discharging hospital on the same day as discharge, the readmitting hospital must enter the name of the discharging hospital, as well as the discharge date, in the appropriate field on the UB-04 claim form.

NOTE: Hospitalized beneficiaries are covered by the type coverage in effect at the time of admission, either FFS or MCO, until discharge. For example, if a FFS beneficiary is hospitalized on December 31 at 12:00 am but is enrolled in an MCO effective January 1, the hospitalization is covered by FFS.

Hospital Services Furnished Under Arrangements

Hospitals are allowed by Medicaid to contract or make arrangements with an outside supplier, including another provider such as an independent laboratory, for performance of medically necessary services for their patients. It is the responsibility of the hospital to ensure that the outside supplier or other provider meets all applicable state and federal requirements.

When a hospital contracts with an outside supplier or another provider for the performance of a routine service or ancillary provider component (technical component of a service), the supplier/provider bills the hospital and is paid by the hospital. Only the hospital is allowed to submit claims to the MCO for services furnished under this arrangement. The services are covered hospital services and reimbursement is included in the hospital reimbursement rates. The MCO may not separately reimburse the outside supplier for services performed on enrollees who are hospital patients. This policy applies to both inpatient and outpatient hospital services.

Trade Area

Acute care out-of-state providers in the trade area are treated the same as in-state providers. Trade area is defined as the counties located in Mississippi, Arkansas, and Texas that border the state of Louisiana.

The following is a list of counties located in the trade area:

Louisiana Trade Area		
Arkansas Counties	Mississippi Counties	Texas Counties
Chicot County	Hancock County	Cass County
Ashley County	Pearl River County	Marion County
Union County	Marion County	Harrison County
Columbia County	Walthall County	Panola County
Lafayette County	Pike County	Shelby County
Miller County	Amite County	Sabine County
	Wilkerson County	Newton County
	Adams County	Orange County
	Jefferson County	Jefferson County

Louisiana Trade Area		
Arkansas Counties	Mississippi Counties	Texas Counties
	Claiborne County	
	Washington County	
	Issaquena County	
	Warren County	

A referral or transfer made by a trade area hospital to another hospital does not constitute approval unless it is to either a Louisiana hospital or another trade area hospital. Prior authorization is required for all other non-emergency referrals or transfers.

Inpatient Hospital Services

Inpatient hospital care is defined as care needed for the treatment of an illness or injury which can only be provided safely and adequately in a hospital setting and includes those basic services that a hospital is expected to provide. The MCO shall not reimburse for care that can be provided in the home or for which the primary purpose is of a custodial or cosmetic nature.

The following requirements are applicable to hospital inpatient services. The MCO must ensure that its policies are in alignment with the requirements described below:

- Inpatient hospital services must be ordered by the following:
  - Attending physician, or other licensed and qualified health care provider;
  - An emergency room physician; or
  - Dentist (if the patient has an existing condition which must be monitored during the performance of the authorized dental procedure).
- Each day of an inpatient stay must be medically necessary.
- Physicians responsible for an enrollee's care at the hospital are responsible for deciding whether the enrollee should be admitted as an inpatient. Place of treatment must be based on medical necessity.
- The MCO shall require prior authorization for out-of-state non-emergency hospitalization, unless the request for hospitalization is for a dual Medicare/Medicaid eligible enrollee. Additional service authorization requirements and exclusions are defined in the Contract.

Abortions

For detailed requirements around abortions, see the corresponding section in the *Professional Services* section of this Manual.

Hospital claims associated with an induced abortion, and those of the attending physician, hospital, assistant surgeon, and anesthesiologist, as applicable, shall be accompanied by a copy of the attending physician's written certification of medical necessity or the Certification of Informed Consent--Abortion form. Therefore, the MCO shall require providers to submit only hard-copy claims for payment consideration.

All claim forms and attachments shall be retained by the MCO. The MCO shall forward a copy of the claim and its accompanying documentation to LDH if requested.

Boarder Baby Per Diem

Babies that are not medically appropriate for discharge and remain hospitalized in the regular nursery after the mother's discharge are referred to as "boarder babies". In these cases, the nursery per diem identified on the Louisiana Medicaid Inpatient Hospital Per Diem Fee Schedule shall be the minimum rate paid to hospitals billing the appropriate and covered nursery revenue codes.

Covered and Non-Covered Inpatient Hospital Days

The MCO shall require hospitals to bill covered days and their associated ancillary charges. Covered days are days that have been approved through the precertification process.

The MCO may permit hospitals to bill non-covered days and their associated ancillary charges but these must be billed separately from covered days and their associated ancillary charges. Non-covered days are days that are not certified or approved by the MCO. Even though these non-covered days and services will be denied by the MCO, the MCO must submit a denied encounter for these claims if billed by the provider.

When the MCO receives an inpatient claim (electronic or paper) that includes dates of service that exceed approved days, the MCO must deny the entire claim. The provider must resubmit the inpatient claim for covered days only.

For example: If a provider obtains approval for a 10-day stay and submits a claim for 12 days, the claim must be denied and resubmitted for the 10 approved days only.

Patient Day Recording

The MCO shall count the number of days of care charged to an enrollee for inpatient hospital services in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in counting days of care for Medicaid reporting purposes. A part of a day, including the day of admission, counts as a full day. However, the day of discharge or death is not counted as a day unless discharge or death occurs on the day of admission. If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day.

837I Billing Instructions

Service Line Items (SV203) – Line Item Charge Amount is the total charge amount for the Service-Line; it includes covered charges and non-covered charges (applicable for covered days only).

For accommodation service line items, the number of covered accommodation service days value (quantity) shall be sent in SV205 along with SV204 set to "DA" (days).

If the provider identifies service line items with non-covered charges or line item charges that are denied by the MCO, the non-covered charges must be identified and reported in the SV207 on the encounter.

The CLM02 (Total Claim Charge Amount) value shall equal the sum of all of the SV203 (Line Item Charge Amount) values. Since the SV203 value includes both covered and non-covered charges, CLM02 also includes both.

HI*BE:80 – Covered Service Days (value in whole numbers only).

Deliveries Prior to 39 Weeks

The MCO shall not cover induced deliveries prior to 39 weeks gestation unless it is medically necessary to induce labor prior to 39 weeks gestation. MCOs must have processes in place to validate that the delivery was not induced prior to 39 weeks or if prior to 39 weeks, that it was medically necessary.

Deliveries with Non-Reimbursable Sterilizations

The MCO shall cover an inpatient hospital claim for a delivery/cesarean section even when a non-reimbursable sterilization is performed during the same hospital stay.

When there is no valid sterilization form obtained, the procedure code for the sterilization and the diagnosis code associated with the sterilization must not be reported on the claim form, and charges related to the sterilization process must not be included on the claim form. Providers will continue to receive their per diem for covered charges for these services.

NOTE: A sterilization procedure is considered non-reimbursable if the sterilization consent form is either missing or invalid.

Distinct Part Psychiatric Units

Medicaid recognizes distinct part psychiatric units within an acute care general hospital differently for reimbursement purposes if the unit meets Medicare's criteria for exclusion from Medicare's Prospective Payment System (PPS excluded unit). The unit must have the LDH HSS verify that the Unit is in compliance with the PPS criteria and identify the number and location of beds in the psychiatric unit.

Hospital-Based Ambulance Services (Inpatient — Air and Ground)

If a hospital admits an inpatient that is transported by its own hospital-based ambulance (ground or air), the MCO shall cover the ambulance charges, which must be billed as part of inpatient hospital services.

It may be necessary to transport an inpatient temporarily to another hospital for specialized care while the enrollee maintains inpatient status. These services are not billable ambulance services.

If a hospital-based ambulance transports an enrollee for inpatient admission to any other hospital, the ambulance service is not part of the hospital service and may be covered under the independent ambulance provider number.

Hospital-based ambulances must meet equipment and personnel standards set by the Bureau of Emergency Services (EMS). Hospitals must submit a copy of the EMS certification to Provider Enrollment for recognition to bill ambulance services.

Hysterectomies

For detailed requirements around coverage of hysterectomies, please see the corresponding section of the *Professional Services* section of this Manual.

Prior to providing payment to the provider performing the hysterectomy, the MCO shall ensure that the hysterectomy consent form or a physician's written certification is obtained. The MCO shall allow ancillary providers and hospitals to submit claims without the hard copy consent. The MCO shall reimburse these providers only if the provider performing the hysterectomy submitted a valid hysterectomy consent form and was reimbursed for the procedure.

The MCO shall retain all required documentation.

Intensive Care Units

Neonatal Intensive Care Units

Reimbursement methodology recognizes four categories of neonatal units based on the certification of a hospital to provide neonatal intensive care services at a minimum standard for each category of Neonatal Intensive Care Units (NICUs): NICU I, NICU II, NICU III, and NICU III Regional.

Pediatric Intensive Care Units

Reimbursement methodology recognizes two categories of Pediatric Intensive Care Units (PICUs) based on the certification of a hospital to provide pediatric intensive care services at a minimum standard for each category of PICU: PICU II; and PICU I.

Mother/Newborn/Nursery

The MCO shall cover a hospital stay following a normal vaginal delivery of at least 48 hours for both the mother and newborn child, and at least 96 hours following a cesarean section delivery for both the mother and newborn child. All medically necessary services are the responsibility of the MCO regardless of primary or secondary mental health diagnosis.

The MCO shall require providers to bill mother and newborn claims separately. The claim is to include only the mother's room/board and ancillary charges. A separate claim for the newborn must include only nursery and ancillary charges for the baby. This newborn claim shall be paid at zero as opposed to being denied in order to be counted as a covered service in encounter data.

When a newborn remains hospitalized after the mother's discharge, the claim must be split billed. The first billing of the newborn claim must be for charges incurred on the dates that the mother was hospitalized. The second billing must be for the days after the mother's discharge. The newborn assumes the mother's discharge date as his or her admit date.

Outliers

In compliance with the requirement of Section 1902(s)(1) of the Social Security Act, additional payment shall be made for catastrophic costs associated with services provided to:

- Children under age six who received inpatient services in a disproportionate share hospital setting, and
- Infants who have not attained the age of one year who received inpatient services in any acute care setting.

Outlier payments are not payable for transplant procedures and services provided to enrollees with Medicaid coverage that is secondary to other payer sources.

Outlier payments are calculated based on each hospital's eligible outlier claims for discharges during the state fiscal year. Payment per hospital is limited to their pro rata share of the annual catastrophic outlier pool amount as established by rule and approved Louisiana Medicaid State Plan. Claims qualifying for payment from the outlier pool must meet the following conditions:

- The claims must be for children less than six years of age who received inpatient services in a disproportionate share hospital setting; or infants less than one year of age who receive inpatient services in any acute care hospital setting; and
- The costs of the case must exceed $150,000. The hospital specific cost-to-charge ratio utilized to calculate the claim costs shall be calculated using the Medicaid NICU or PICU costs and charge data from the most current cost report.

Out-of-State Acute Care Hospitals

Psychiatric and Substance Abuse

The MCO shall cover inpatient psychiatric or substance abuse treatment in out-of-state hospitals for a maximum of two days in the case of a medical emergency.

Out-of-State Inpatient Psychiatric Services

The MCO shall cover inpatient stays for psychiatric or substance abuse treatment in out-of-state hospitals only in the event of a medical emergency for a maximum of two days to allow time for the enrollee to be stabilized and transferred to a Louisiana psychiatric hospital when appropriate. The MCO shall not cover outpatient psychiatric and substance abuse services provided by an out-of-state hospital.

Psychiatric Diagnosis within an Acute Care Hospital

When the enrollee's primary diagnosis is psychiatric, reimbursement will be on the psychiatric per diem and not the long-term or acute care rate.

Psychiatric Hospitals (Free-Standing and Distinct Part)

Reimbursement for services provided in these facilities is a prospective per diem rate. This per diem includes all services provided to inpatients, except for physician services, which must be billed separately. All therapies

(individual/group counseling or occupational therapy) must be included in the per diem. Federal regulations prohibit Medicaid reimbursement for enrollees ages 22-64 in a free-standing psychiatric hospital setting except as an LDH-approved in-lieu-of service.

Rehabilitation Units in Acute Care Hospitals

Rehabilitation Units (Medicare designated) are considered part of the acute care hospital, and services are to be billed with the acute care provider number. Reimbursement rates are the same as for the acute care hospital. Separate Medicaid provider numbers are not issued for rehabilitation units.

Services Reimbursed Separately from Per Diem Rate

Hospitals are to be reimbursed on an all-inclusive per diem for services provided. The MCO is required to reimburse hospitals the minimum per diem as published on the Medicaid FFS fee schedule. However, the following services, if provided in an inpatient setting, are to be reimbursed in addition to the minimum per diem:

- Cochlear devices
- Donor human milk
- Intraocular lens implants*
- Intrathecal baclofen therapy infusion pumps
- Long acting reversible contraceptives
- Newborn screening panels performed in acute care hospital settings
- Vagus nerve stimulator devices*

*Refer to the *Outpatient Hospital Services* section for additional detail about these services.

Cochlear Implants

For detailed requirements around coverage of cochlear implants, see the corresponding section of the *Professional Services* section.

When the implantation procedure is performed in the hospital setting, the MCO shall reimburse the hospital for the device(s) in addition to the hospital payment.

Donor Human Milk

The MCO shall cover donor human milk provided in the inpatient hospital setting for certain medically vulnerable infants. This coverage shall be provided without restrictions or the requirement for prior authorization. Donor human milk is considered medically necessary when all of the following criteria are met:

- The hospitalized infant is less than 12 months of age with one or more of the following conditions:
  - Prematurity;
  - Malabsorption syndrome;
  - Feeding intolerance;
  - Immunologic deficiency;
  - Congenital heart disease or other congenital anomalies;

- Other congenital or acquired condition that places the infant at high risk of developing necrotizing enterocolitis (NEC) and/or infection; and

- The infant's caregiver is medically or physically unable to produce breast milk at all or in sufficient quantities, is unable to participate in breastfeeding despite optimal lactation support, or has a contraindication to breastfeeding; and
- The infant's caregiver has received education on donor human milk, including the risks and benefits, and agrees to the provision of donor human milk to their infant; and
- The donor human milk is obtained from a milk bank accredited by, and in good standing with, the Human Milk Banking Association of North America.

Reimbursement

The MCO shall reimburse donor human milk separately from the hospital reimbursement for inpatient services. The minimum reimbursement for the donor human milk is the fee on file on the Louisiana Medicaid Durable Medical Equipment (DME) Fee Schedules.

Hospitals must bill the donor human milk claim using the Healthcare Common Procedure Coding System (HCPCS) procedure code T2101 (1 unit per ounce) on a CMS 1500 claim form.

Intrathecal Baclofen Therapy

For detailed requirements around coverage of intrathecal baclofen therapy, see the corresponding section in the *Professional Services* section of this Manual.

When the implantation procedure is performed in the hospital setting, the MCO shall reimburse the hospital for the pump in addition to the hospital reimbursement.

Long-Acting Reversible Contraceptives in the Inpatient Hospital Setting

The MCO shall cover long-acting reversible contraceptive (LARC) devices, in addition to the hospital reimbursement, when provided in the postpartum period prior to discharge. Minimum reimbursement for the LARC device is provided on the Louisiana Medicaid Durable Medical Equipment (DME) Fee Schedules. Hospitals shall bill the claim for the LARC, separate from the inpatient stay, on the CMS 1500 claim form.

Specialty Units

Certain resource intensive inpatient services are recognized through a separate reimbursement methodology by Louisiana Medicaid. The MCO shall refer to the corresponding rate applicable to the type and level of service in the Medicaid FFS fee schedule for the minimum per diems established for the following inpatient services: neonatal intensive care units, pediatric intensive care units, and burn units.

Split-Billing

The MCO must require split-billing in the following circumstances:

- Hospitals must split-bill claims at the hospital's fiscal year end;
- Hospitals must split-bill claims when the hospital changes ownership;

- ❖ Hospitals must split-bill claims if the charges exceed $999,999.99; and
- ❖ Hospitals must split-bill claims with more than one revenue code that utilizes specialized per diem pricing (e.g., PICU, NICU).

The MCO may grant hospitals the discretion to split-bill claims as warranted by other situations that may arise.

Split-Billing Procedures

The MCO shall provide the following instructions for split-billing on the UB-04 claim form.

In the Type of Bill block (form locator 4), the hospital must enter code 112, 113 or 114 to indicate the specific type of facility, the bill classification, and the frequency for both the first part and the split-billing interim and any subsequent part of the split-billing interim.

In the Patient Status block (form locator 17), the hospital must enter a 30 to show that the enrollee is "still a patient."

NOTE: When split-billing, the hospital must not code the first claim as a discharge.

In the Remarks section of the claim form, the hospital must write in the part of stay for which it is split-billing. For example, the hospital must write in "Split-billing for Part 1," if it is billing for Part 1.

Providers submitting a hospital claim which crosses the date for the fiscal year end, must complete the claim in two parts: (1) through the date of the fiscal year end and (2) for the first day of the new fiscal year.

Sterilizations

For detailed requirements around coverage of sterilizations, see the corresponding section of the *Professional Services* section of this Manual.

Prior to providing reimbursement to the provider performing the sterilization, the MCO shall ensure that the sterilization consent form is obtained. The physician who signs the consent form must be the physician listed as the attending physician on the UB-04.

The MCO shall allow ancillary providers and hospitals to submit claims without the hard copy consent. The MCO shall reimburse these providers only if the provider performing the sterilization submitted a valid sterilization consent and was reimbursed for the procedure.

The MCO shall retain all required documentation.

NOTE: Refer to *Deliveries with Non-Reimbursable Sterilizations* for deliveries when a non-reimbursable sterilization is performed during the same hospital stay.

Surgeries Performed on an Inpatient Basis

The MCO shall cover certain surgical procedures only when performed as outpatient unless it is medically necessary for the procedure to be performed on an inpatient basis. These procedures are usually performed on an outpatient basis but can be performed inpatient if it is medically necessary. A list of outpatient procedures requiring approval to be performed on an inpatient basis may be found on the Medicaid FFS fee schedules.

The MCO may approve inpatient performance of these procedures when one or more of the following exception criteria exists:

- Documented medical conditions exist that make prolonged pre-and/or post-operative observation by a nurse or skilled medical personnel a necessity.
- The procedure is likely to be time consuming or followed by complications.
- An unrelated procedure is being performed simultaneously that requires hospitalization.
- There is a lack of availability of proper post-operative care.
- Another major surgical procedure could likely follow the initial procedure (e.g., mastectomy).
- Technical difficulties, as documented by admission or operative notes, could exist.
- The procedure carries high enrollee risk.

Reimbursement for the performance of these specified surgical procedures on an outpatient basis will be made on a flat fee-for-service basis. Reimbursement for surgical procedures approved for an inpatient performance will be made in accordance with the prospective reimbursement methodology for acute care inpatient hospital services.

Transplant Services

In-state transplant services are reimbursed at costs subject to a hospital-specific per diem limit that is based on each hospital's actual cost in the base year established for each type of approved transplant. Out-of-state transplant services are reimbursed at 40 percent of billed charges for adults age twenty-one and older and 60 percent of billed charges for children through age twenty.

Well-Baby Per Diem

Private hospitals that perform more than 1,500 Louisiana Medicaid deliveries per state fiscal year (SFY) qualify to be paid a per diem for well babies that are discharged at the same time the mother is discharged.

Outpatient Hospital Services

Outpatient hospital services are defined as diagnostic and therapeutic services rendered under the direction of a physician or dentist to an outpatient in an enrolled, licensed and certified hospital. The MCO shall cover medically necessary outpatient hospital services provided to enrollees.

Common Observation Policy

The MCO shall utilize the following common observation policy, which has been developed collectively by MCO personnel with LDH approval. This policy shall be reviewed annually by LDH and the MCOs in its entirety. Any revisions shall be reviewed and approved by LDH at least 30 calendar days prior to implementation of any new or revised language. The purpose of the outpatient hospital services program is to provide outpatient services to eligible Medicaid enrollees performed on an outpatient basis in a hospital setting. Hospitals are to ensure that the services provided to Medicaid enrollees are medically necessary, appropriate and within the scope of current evidence-based medical practice and Medicaid guidelines.

***Observation Time**: The period beginning at the time the order is written to place an enrollee in observation status or the time an enrollee presents to the hospital with an order for observation, and ending with discharge of the enrollee, or an order for inpatient admission.*

***Observation Care**: A well-defined set of specific, clinically appropriate services furnished while determining whether an enrollee will require formal inpatient admission or be discharged from the hospital. Observation is for a minimum of one hour and up to 48 hours.*

**The enrollee must be in the care of a physician during the period of observation, as documented in the medical record by an observation order, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.*

Observation Procedure

The MCO shall reimburse up to 48 hours of medically necessary care for an enrollee to be in an observational status. This time frame is for the physician to observe the enrollee and to determine the need for further treatment, admission to an inpatient status, or for discharge. Observation and ancillary services do not require notification, precertification or authorization and will be covered up to 48 hours.

Hospitals should bill the entire outpatient encounter, including emergency department, observation and any associated services on the same claim with the appropriate revenue codes, and all covered services are to be processed and paid separately.

Any observation service over 48 hours requires MCO authorization. For observation services beyond 48 hours that are not authorized, the MCO shall only deny the non-covered hours.

If an enrollee is anticipated to be in observation status beyond 48 hours, the hospital must notify the MCO as soon as reasonably possible for potential authorization of an extension of hours. The MCO and provider shall work together to coordinate the provision of additional medical services prior to discharge of the enrollee as needed.

Observation-to-Inpatient Procedure

Length of stay alone should not be the determining factor in plan denial of inpatient stay/downgrading to observation stay.

Medicaid enrollees should not be automatically converted to inpatient status at the end of the 48 hours. Admission of an enrollee cannot be denied solely on the basis of the length of time the enrollee actually spends in the hospital.

All hospital facility charges on hospital day one are included in the inpatient stay and billed accordingly inclusive of emergency department/observation facility charges. (Note: Professional charges should continue to be billed separately.)

All observation status conversions to an inpatient hospital admission require notification to the MCO within one business day of the order to admit an enrollee. Acceptable notifications include the use of MCO provider portals, admit discharge transfer notifications, and other mediums through which MCOs accept clinical communications.

MCOs are prohibited from including any observation hours in the inpatient admission notification period.

The MCO will notify the provider rendering the service, whether a healthcare professional or facility or both, verbally or as expeditiously as the enrollee's health condition requires but within no more than one business day of making the initial determination. The MCO will subsequently provide written notification (i.e., via fax) to the provider within two business days of making the decision to approve or deny an authorization request.

Observation Charges

The MCO must require hospitals to bill for observation services following the common observation policy. Observation services must be billed using revenue code 762 and the appropriate accompanying HCPCS codes of G0378 and G0379.

MCOs may not reimburse for outpatient surgical procedures provided on the same day as observation.

Diabetes Self-Management Training

For detailed requirements around coverage of diabetes self-management training, see the corresponding subsection of the *Professional Services* section of this Manual.

The MCO shall reimburse for DSMT services as a flat fee based on the Louisiana Medicaid Professional Services Fee Schedule, at a minimum, minus the amount which any third party coverage would pay. The following Healthcare Common Procedure Coding System (HCPCS) codes or their successors are used to bill DSMT services:

- G0108-Diabetes outpatient self-management training services, individual, per 30 minutes
- G0109-Diabetes self-management training services, group session (two or more) per 30 minutes

NOTE: Services provided to pregnant women with diabetes must be billed with the "TH" modifier.

Hospitals are to bill the above HCPCS codes in the outpatient setting along with Revenue code 942. These are the only HCPCS codes currently allowed to be billed with HR942.

Emergency Department Services

The MCO shall cover emergency department services for an emergency medical condition, subject to the "prudent layperson standard" as required in federal law and regulations. A person with an emergency medical condition presents with a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in:

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

Hospitals with emergency departments are required by EMTALA (Emergency Medical Treatment and Labor Act) to perform a Medical Screening Exam (MSE) on all persons who present to the emergency department for services. If the MSE does not reveal the existence of an emergency medical condition under the prudent layperson standard, the enrollee must be advised that Medicaid does not cover routine/non-emergent care provided in the emergency department when the presenting symptoms do not meet the prudent layperson standard of an emergency condition and that he or she may receive a bill if they are treated in the emergency department. The enrollee must be referred to his or her primary care physician (PCP) for follow-up and evaluation.

Federal Medicaid regulations and policy prohibit the use of diagnosis codes (either symptoms or final diagnosis) for denying claims. The MCO is required to base coverage decisions for emergency services on the apparent severity of the symptoms at the time of presentation and to cover examinations when presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. The final determination of coverage and reimbursement must be made by taking into account the presenting symptoms rather than the final diagnosis.

The MCO shall require provider to bill revenue code 450 or 459 when submitting claims for outpatient emergency department services. Only one revenue code 450 or 459 may be used per emergency department visit. These revenue codes must be billed with the appropriate accompanying CPT codes of 99281, 99282, 99283, 99284, 99285, 99291 and 99292. Claims for emergency department services are not to be billed as a single line item. Claims must include all revenue codes (i.e., pharmacy, lab, x-rays and supplies) which were utilized in the enrollee's treatment, using the appropriate revenue code and HCPCS when applicable.

When an emergency visit results in an inpatient admit, providers must bill all charges associated with the emergency visit on the inpatient bill. This policy applies to enrollees admitted from the emergency department or if the enrollee has been seen in the emergency department within 24 hours either prior to admit or after the inpatient discharge. The emergency department charges must be billed as a separate line. All associated charges for the emergency visit must be included by revenue code with the total charges for the inpatient stay.

Hospital-Based Ambulances (Outpatient — Ground only)

The MCO shall cover emergency transports by a hospital's own hospital-based ambulance (ground only) for enrollees treated and released as an outpatient. These must be billed as part of outpatient hospital services.

If a hospital-based ambulance transports a patient for emergency outpatient treatment to any other hospital, the ambulance service is not part of the hospital service and may be covered under the independent ambulance provider number.

Hospital-based ambulances may be used only to transport enrollees to the hospital in an emergency so they may be stabilized.

The MCO shall not cover non-emergency transport by a hospital-based ambulance as a hospital service.

NOTE: Air ambulance is not covered as an outpatient service.

Hospital-based ambulances must meet equipment and personnel standards set by the Bureau of Emergency Medical Services (EMS). Hospitals must submit a copy of EMS certification to Provider Enrollment for recognition to bill ambulance charges.

Hyperbaric Oxygen Therapy

The MCO shall cover hyperbaric oxygen therapy when provided in an outpatient hospital setting. For detailed requirements related to hyperbaric oxygen therapy coverage, see the corresponding subsection of the *Professional Services* section in this Manual.

Intraocular Lens Implants

When intraocular lens implantation is performed in the outpatient hospital setting, the MCO shall reimburse for the intraocular lens implant in addition to the outpatient hospital surgery reimbursement. The MCO shall only reimburse the provider who actually supplies the lens.

Long-Acting Reversible Contraceptives in the Outpatient Hospital Setting

The MCO shall make an additional reimbursement to hospitals for long-acting reversible contraceptive (LARC) devices when they are inserted during an outpatient hospital visit. Reimbursement for the LARC device in the outpatient hospital setting is in addition to the outpatient hospital reimbursement.

Hospitals shall bill the DME revenue code of 290 with the appropriate accompanying HCPCS code for the LARC device on the UB-04. The MCO may refer to the Louisiana Medicaid Durable Medical Equipment (DME) Fee Schedules for covered LARCs and their minimum reimbursement.

NOTE: Refer to the *Inpatient Hospital Services* section for LARCs in the inpatient hospital setting.

Out-of-State Hospital Outpatient Services

Approved outpatient hospital services will be reimbursed at 31.04 percent of billed charges except for those outpatient services reimbursed based on a fee schedule. The Medicaid Program does not cost settle out-of-state hospitals.

Outpatient Hospital Clinic Services

The payable revenue codes are 510, 514, 515, 517, and 519. These revenue codes must be billed with the appropriate accompanying office setting E&M CPT code.

Outpatient Rehabilitation Services

The MCO shall cover outpatient rehabilitation services, which include:

- Physical therapy;
- Occupational therapy;
- Speech therapy; and
- Hearing therapy.

Proton Beam Radiation Therapy

The MCO shall not cover Proton Beam Radiation Therapy (PBRT) for enrollees 21 years of age and older.

Psychiatric and Substance Abuse

The MCO shall not cover outpatient psychiatric or substance abuse treatment in an outpatient hospital setting.

Same-Day Outpatient Visits

Enrollees under Age 21

When medically necessary, two same-day outpatient visits per specialty per enrollee are allowed; however, the second same-day outpatient visit is reimbursable for only the two lowest level evaluation and management (E&M) codes.

If an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening has been paid, only the two lowest level E&M codes are payable for the same enrollee, on the same date of service and by the same attending provider. In these circumstances, when it is clinically appropriate, providers may use the correct modifier to allow both services to be covered

A same-day follow-up office visit for the purpose of fitting eyeglasses is allowed, but no higher level office visit than the lowest level E&M code is payable for the fitting. Appropriate modifier usage may be required.

Enrollees Age 21 and Over

If a preventive medicine E&M service has been paid, only the two lowest level E&M codes are payable for the same enrollee, on the same date of service, and by the same attending provider.

Screening Mammography

For requirements related to screening mammography coverage, see the corresponding subsection of the *Professional Services* section in this Manual.

The MCO shall reimburse hospitals billing with revenue code 403 and the appropriate accompanying CPT codes for screening mammograms.

Vagus Nerve Stimulators

For detailed requirements around vagus nerve stimulator coverage, please see the corresponding subsection in the *Professional Services* section of this Manual.

The MCO shall advise hospitals to confirm that the provider performing the implantation has received an authorization for the procedure prior to submitting their claim in order to prevent denials. The MCO shall reimburse for vagus nerve stimulators using HCPCS procedure code C1767 (VNS generator) and/or C1778 (VNS leads). The MCO shall reimburse following review of the provider's approved authorization.

LABORATORY SERVICES

The MCO shall cover inpatient and outpatient (hospital and non-hospital) laboratory services when ordered by a physician or other licensed practitioner acting within their scope of practice. The MCO shall cover laboratory services that may be required to treat an emergency or to provide surgical services for an excluded service, such as dental services.

CLIA Certification

The MCO shall require all providers to include a valid Clinical Laboratory Improvement Amendments (CLIA) number on all claims submitted for laboratory services, including CLIA waived tests.

The MCO shall apply CLIA claim edits to all claims for laboratory services that require CLIA certification and deny those claims that do not meet the required criteria.

The MCO shall edit claims to ensure reimbursement is not made to:

- Providers who do not have a CLIA certificate;
- Providers rendering services outside the effective dates of the CLIA certificate; and
- Providers submitting claims for services not covered by their CLIA certificate.

Providers with waiver or provider-performed microscopy (PPM) certificate types may be paid for only those waiver and/or PPM codes approved for billing by CMS.

NOTE: The CLIA number is not required for UB-04 claims.

In-Office Laboratory Services

The MCO shall cover laboratory services furnished in an office or similar facility other than a hospital outpatient department or clinic. The MCO must only reimburse physicians and other licensed practitioners for laboratory services that they personally perform or supervise and must ensure that physicians and other licensed practitioners comply with all state and federal requirements.

Hospital Laboratory Services

The MCO shall cover laboratory services furnished in a hospital laboratory.

For inpatient laboratory services, the MCO shall allow hospitals to contract with an independent laboratory. The MCO shall ensure that the hospital pays the laboratory for the technical component. The MCO shall reimburse the independent laboratory for only the professional component of the service, when applicable.

For outpatient laboratory services, the MCO shall allow hospitals to contract with an independent laboratory. When a hospital contracts with an independent laboratory for the performance of the technical service only, the MCO shall require the hospital to pay the laboratory. The MCO shall not reimburse the independent laboratory for the technical component only.

When a hospital contracts with an independent laboratory for outpatient or inpatient services, the MCO shall require the hospital to ensure that both the physician who performs the professional service and the laboratory that performs the technical service meet all applicable state and federal requirements.

Independent Laboratories

The MCO shall cover laboratory services provided in independent laboratories. An independent laboratory performs diagnostic tests and is independent of the ordering provider, the hospital, or both.

The MCO shall only contract with independent laboratories that meet all applicable state and federal requirements.

Providers are limited to billing the laboratory services that they are CLIA-certified to perform.

Specimen Collection

The MCO shall not reimburse separately for specimen collection, as that service is considered incidental to the evaluation and management service, the laboratory test, or both.

Urine Drug Testing

The MCO shall cover presumptive and definitive urine drug testing under the following parameters:

- Presumptive drug testing is limited to 24 total tests per enrollee per calendar year.
- Definitive drug testing is limited to 12 total tests per enrollee per calendar year.
- Testing more than 14 definitive drug classes in one test is not reimbursable.
- No more than one presumptive test and one definitive test shall be reimbursed per day per enrollee, from the same or different provider.

MEDICAL TRANSPORTATION

The MCO is required to provide emergency and non-emergency medical transportation for its enrollees. Coverage information by enrollment type is provided in the following matrix:

Enrollment	Non-Ambulance	Non-Emergency Ambulance	Emergency Ambulance
Managed care for physical and behavioral health	MCO	MCO	MCO
Managed care for physical health only (CSoC children)	MCO	MCO	MCO
Managed care for behavioral health only	MCO	MCO	Medicaid FFS
Nursing home residents	Included in facility per diem	MCO	MCO for month of admission*; Medicaid FFS for subsequent months

Children in ICF-IIDs†	Included in facility per diem	MCO	Medicaid FFS
Adults in ICF-IIDs†	Included in facility per diem	Medicaid FFS^	Medicaid FFS
Excluded populations	Medicaid FFS^	Medicaid FFS^	Medicaid FFS

† Intermediate Care Facility for Individuals with Intellectual Disabilities

^ Southeastrans is currently authorizing and reimbursing for these transportation services covered by Medicaid FFS.

*During the single transitional month where an enrollee is both in a P-linkage and certified in LTC, the MCO will remain responsible for all transportation services that are not the responsibility of the nursing facility.

The MCO may elect to contract with a transportation broker but shall maintain ultimate responsibility for adhering to and otherwise fully complying with the policies, instructions, and guidelines herein, any applicable Contract provisions, and any applicable state and federal requirements.

Non-Emergency Medical Transportation

Non-Emergency Medical Transportation (NEMT) is transportation provided to Medicaid enrollees to and/or from a Medicaid provider for a Medicaid covered service when no other means of transportation are available. NEMT does not include transportation provided on an emergency basis, such as trips to emergency departments in life threatening situations. Non-emergency ambulance transportation (NEAT) is a form of NEMT. See the *Ambulance* section of this Manual for guidelines specific to NEAT. Services shall be provided in accordance with the Louisiana Administrative Code, Title 50, Part XXVII, Chapter 5.

Covered Services

The MCO shall authorize NEMT for the least costly means of transportation available to and/or from a qualified provider of routine or specialty care within the enrollee's transportation service area. The transportation service area is defined as the area that complies with the geographic access standards outlined in the **Provider Network Companion Guide**.

Scheduled trips in which no transportation of the enrollee occurs are not billable.

Reimbursement to transportation providers shall be no less than the published Medicaid FFS rate in effect on the date of service, unless mutually agreed to by the MCO and the transportation provider in the provider agreement.

Exceptions to Standards

The transportation service area applies for P-linkage enrollees who are enrolled in an MCO for physical health, behavioral health, and transportation services. It is not applicable to B-linkage enrollees who are enrolled in an MCO for specialized behavioral health and NEMT, including NEAT.

If a P-linkage enrollee does not have a choice of at least two medical providers within the geographic access standards, the transportation service area may be extended to the nearest medical provider beyond the geographic access standards.

Enrollees may seek medically necessary services in another state when it is the nearest option available. All non-emergency out-of-state transportation must be prior authorized by the MCO. The MCO may approve transportation to out-of-state medical care only if the enrollee has been granted approval to receive medical treatment out of state.

The MCO must maintain documentation to support exceptions to standards and submit documentation to LDH upon request.

Exclusions

The MCO shall not be reimbursed for transportation to or from the following locations:

- Pharmacies;
- Nursing facilities;
- Hospice care; or
- Women, Infants, and Children (WIC) service appointments at the Office of Public Health.

NOTE: This is not an exclusive list.

The MCO may reimburse for transportation to or from a pharmacy, WIC appointment, or other value-added benefit as an approved MCO value-added benefit, regardless if it is a standalone trip or as an additional stop. The MCO shall flag both the service and the transportation as a value-added benefit in accordance with the **MCO System Companion Guide**.

Commercial Air Transportation for Out-of-State Care

The MCO may approve transportation on commercial airlines for out-of-state trips when no comparable services can be provided in Louisiana, and the risk to the enrollee's health is grave if transported by other means. All out-of-state non-emergency medical care must be prior authorized by the MCO. Transportation may be included in the prior authorization for medical services. MCO approval shall be contingent on the treating physician's confirmation that there are no negative impacts to the health and safety of the enrollee by utilizing commercial air transportation.

The MCO shall reimburse air travel for the enrollee plus a maximum of one attendant, if medically necessary or if the enrollee is a child, at the lowest, refundable, coach/economy class fare. Upgrades (e.g., fare class or seat) and additional costs (e.g., in-flight refreshments) shall not be reimbursed.

Scheduling and Authorization

General Requirements

To be eligible for reimbursement, NEMT trips must be reviewed by the MCO, prior to scheduling, for enrollee eligibility and verification that the originating or destination address belongs to a medical facility. Additional authorization requirements for out-of-state travel, commercial air, and NEAT are addressed in this manual.

Requests for transportation may be made by enrollees, hemodialysis centers, non-profit transportation providers, Opioid Treatment Programs, or other medical facilities. Under no circumstances may profit transportation providers schedule trips on behalf of enrollees.

The MCO shall assign transportation providers on the basis of the least costly means available, including the use of free and/or public transportation when possible, with consideration given to the enrollee's choice of transportation provider. The MCO shall ensure that the provider accommodates the level of service required to safely transport the enrollee (e.g., ambulatory, wheelchair, transfer).

When multiple providers meet the least costly standard, the MCO should dispatch trips to providers whose primary service region for operation, according to the provider's Disclosure of Ownership Form, is the same as the enrollee's domicile and who are able to comply with all travel and wait time standards. The MCO is prohibited from dispatching trips to out-of-region providers, unless the MCO retains documentation to support that there is no willing and available provider in the region[4] where the enrollee is domiciled able to comply with time requirements or that the out-of-region provider is the least costly option.

The MCO must obtain credentials from the transportation provider, driver, and vehicle as outlined in the Provider Requirements section.

Enrollees and medical providers are expected to give at least 48 hours' notice when requesting transportation; however, the MCO must make a reasonable attempt to schedule the trip with less than 48 hours' notice. **Hospital discharges shall be transported within three hours of notification by a medical facility.**

When a transportation provider cannot perform the service, the MCO shall require the provider to immediately notify the MCO in order for the MCO to secure an alternate provider.

The MCO shall monitor providers to ensure that they do not reject local trips in favor of long distance trips. Providers who exhibit a pattern of rejecting local trips may be subject to trip reductions or other sanctions, particularly if such action results in actual harm to an enrollee or places the enrollee at risk of imminent harm.

If a child is to be transported, either as the enrollee or an additional passenger, the parent or guardian of the child is responsible for providing an appropriate child passenger restraint system as outlined by La. R.S. 32:295. The MCO is responsible for notifying the parents or guardians of this requirement when scheduling the trip.

Additional Passengers

The MCO must inform the transportation provider if an enrollee intends to bring accompanying children or if an attendant is required.

The MCO shall not reimburse providers for transporting additional passengers. The MCO shall prohibit transportation providers from charging the enrollee or anyone else for the transportation of additional passengers.

Children

The MCO's policy must allow the transportation provider to refuse to transport accompanying children.

[4] Defined as the LDH administrative regions illustrated at https://ldh.la.gov/index.cfm/page/2.

Attendants

The MCO is responsible for determining if an attendant is required. If required, the MCO shall ensure that the attendant accompany the enrollee to and from the medical appointment. The following non-exclusive list of conditions may require an attendant:

- Sensory deficits;
- Need for human assistance for mobility;
- Dementia or other cognitive impairments;
- At risk of elopement;
- Behavioral disorders;
- Need for interpretation or translation assistance; or
- Special needs such as:
    - Convalescence from surgical procedures;
    - Decubitus ulcers or other problems which prohibit sitting for a long period of time;
    - Incontinence or lack of bowel control;
    - Assistance with toileting; and
    - Artificial stoma, colostomy or gastrostomy.

An attendant shall be required when the enrollee is under the age of 17. This attendant must:

- Be a parent, legal guardian, or responsible person designated by the parent/legal guardian; and
- Be able to authorize medical treatment and care for the enrollee.

Attendants may not:

- Be under the age of 17;
- Be a Medicaid provider or employee of a Medicaid provider that is providing services to the enrollee being transported, except for employees of a mental health facility in the event an enrollee has been identified as being a danger to themselves or others or at risk for elopement; or
- Be a transportation provider or an employee of a transportation provider.

Provider Requirements

Classification of Providers

NEMT is provided to Medicaid enrollees through four classifications of NEMT providers. The MCO shall consider scheduling transportation providers in the following order:

1. Public
2. Gas reimbursement
3. Non-profit
4. Profit

Public providers include city and parish intrastate mass transit systems (e.g., bus, train).

Gas reimbursement providers are individuals, including friends or family members. The provider may not reside at the same physical address as the enrollee being transported.

Non-profit providers include those providers who are operated by or affiliated with a public organization such as state, federal, parish or city entities, community action agencies, or parish Councils on Aging. If a provider qualifies as a non-profit entity according to Internal Revenue Service (IRS) regulations, they may only enroll as non-profit providers.

Profit providers include corporations, limited liability companies, partnerships, or sole proprietors. Profit providers must comply with all state laws and the regulations of any governing state agency, commission, or local entity to which they are subject as a condition of enrollment and continued participation in the Medicaid program.

General Requirements

The MCO shall ensure that the transportation provider agrees to cover the entire parish or parishes for which he or she provides NEMT services.

Gas Reimbursement Provider Requirements

The MCO shall ensure that gas reimbursement providers are 18 years of age or older and possess a current Louisiana driver's license. The provider may not reside at the same address as the enrollee.

In order to be eligible for reimbursement, the MCO must obtain the following from gas reimbursement providers:

- An enrollment form that includes at a minimum:
  - Provider's full name;
  - Provider's physical address (P.O. Box is not valid);
  - Provider's mailing address;
  - Provider's phone number;
  - Provider's social security number; and
  - List of no more than five enrollees or all enrollees within one household, for whom the driver may be reimbursed. Enrollee information must include the full name, date of birth, and Medicaid ID;
- A clear and legible copy of the valid driver's license as part of the enrollment packet; and
- A copy of the vehicle's registration and insurance that meets or exceeds the minimum insurance required by the State of Louisiana.

Reimbursement to gas reimbursement providers is intended to cover all persons in the vehicle at the time of the trip (i.e., reimbursement shall be made for one trip regardless of the number of enrollees or additional passengers in the vehicle).

The MCO shall issue IRS Form 1099 to all gas reimbursement providers for income tax purposes.

Profit and Non-Profit Provider Requirements

The MCO shall obtain credentials from each profit and non-profit NEMT provider prior to and continually thereafter providing services under the NEMT program. The MCO may not assign any trips to profit and non-profit providers at any point who do not meet the requirements of this section. The MCO may not reimburse any provider in violation of these requirements on the date of service.

Administrative Requirements

The MCO shall obtain the following administrative documents from the NEMT provider:

- A disclosure of ownership as required by 42 C.F.R. §§ 455.104-455.106;
- The provider's National Provider Identifier (NPI) number in his or her business entity name if the provider has obtained one from the National Plan and Provider Enumeration System (NPPES);
- A copy of the IRS Form CP 575 showing the Employer Identification Number (EIN) and business entity name which must match all other documentation including, but not limited to, vehicle signage;
- An IRS Form W-9 which matches the information on the IRS Form 575;
- A Certificate of Public Necessity (CPNC) issued by the Orleans Parish Taxicab Service and Enforcement Bureau for each provider, driver, and vehicle that will operate in Orleans Parish; and
- An NEMT permit issued by the Jefferson Parish Emergency Management Office for each provider, driver, and vehicle that will operate in Jefferson Parish.

The MCO shall conduct a search of Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), Louisiana Adverse Actions List Search, the System of Award Management (SAM), and other applicable sites as may be determined by LDH, monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered shall be reported to LDH within three business days. Any individual or entity that employs or contracts with an excluded NEMT provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This is a prohibited affiliation. This prohibition applies even when the Medicaid reimbursement itself is made to another provider who is not excluded.

The MCO is responsible for the return to the State of any money paid for services provided by an excluded NEMT provider within 30 days of discovery. Failure by the MCO to ensure compliance with requirements to prevent and return, as applicable, payments to excluded providers may also result in LDH assessing monetary penalties and/or other remedies including, but not limited to, a deduction from the MCO's monthly capitation payment.

Insurance Requirements

The MCO shall ensure that profit and non-profit NEMT providers have, at a minimum, general liability coverage of $100,000 on the business entity, in addition to automobile liability coverage of $25,000 for bodily injury per person, $50,000 per accident, and $25,000 for property damages. Any NEMT provider authorized to transport an enrollee out of state must carry automobile liability of $1,500,000, at a minimum, in accordance with federal transportation regulations. Automobile liability coverage should include either:

- Symbols 7, 8, and 9; or
- Symbols 2, 8, and 9.

The NEMT provider's certificate of insurance must state that this coverage is for a Non-Emergency Medical Transportation Vehicle. The policy must have a 30-day cancellation clause issued to the MCO. LDH must be listed as an additional insured on the automobile liability and general liability policies. The MCO shall obtain a copy of the policy from the provider.

If a transportation provider adds a vehicle, the MCO shall obtain from the NEMT provider an updated copy of the policy, which shows that the additional vehicle is insured, prior to use of the vehicle.

The MCO shall ensure that all transportation companies carry worker's compensation insurance as required by Louisiana law.

Operation without the minimum insurance coverage is a violation of the NEMT provider requirements. LDH or the MCO may recoup all payments for trips occurring during the period of violation.

Driver Requirements

Drivers shall meet the following minimum requirements in order to transport Medicaid enrollees:

- Be 25 years of age or older;
- Possess a current driver's license (class D or CDL);
- Possess the appropriate municipal or parochial permits if operating in Orleans and Jefferson Parish;
- Have an Official Driving Record with neither three or more moving violations, nor any convictions for operating a vehicle while intoxicated, within the past three years;
- Comply with La. R.S. 40:1203.1 - 40:1203.7. Transportation providers shall conduct an annual criminal history check on all NEMT drivers. The criminal history check must be performed by the Louisiana State Police, an agency authorized by the Louisiana State Police, or the FBI. The results of the criminal history check must be transmitted directly to the MCO or its transportation broker by the authorizing agency. The driver must have a "clean" record, with no convictions for prohibited crimes, unless the person has received a pardon of the conviction or has had his or her conviction expunged; and
- Have successfully passed a five-panel drug screen, at a minimum, which shall be performed annually and upon reasonable suspicion. The results of the drug screen must be transmitted directly to the MCO by the testing agency. Any driver, or prospective driver, who fails the drug screen may resume driver responsibilities after a substance abuse professional issues a final evaluation and return to work clearance. The MCO shall confirm that the driver successfully completes three follow-up screens over the six-month period following return to duty.

The MCO shall obtain documentation demonstrating compliance with these requirements.

Training Requirements

NEMT drivers shall complete the following training requirements prior to transporting any Medicaid enrollees:

- Defensive driving, utilizing an in-person course (online courses are not acceptable) of no less than four hours, to be renewed every three years, at a minimum;
- Cardiopulmonary resuscitation (CPR), culminating in an active certification issued by a licensed instructor;
- Child passenger restraint systems, including installation and usage in compliance with La. R.S. 32:295;
- Wheelchair securement and Passenger Assistance Safety and Sensitivity (PASS), utilizing an in-person course, to be renewed every two years, at a minimum; and
- Health Insurance Portability and Accountability Act (HIPAA) privacy and security.

The MCO shall obtain supporting documentation and ensure compliance with driver training requirements.

Vehicle Requirements

The MCO shall ensure that each vehicle authorized to transport enrollees under the NEMT program attains compliance with all vehicle requirements prior to transporting any Medicaid enrollees and maintains compliance thereafter.

General Requirements

The transportation provider shall own or lease its vehicles. The MCO shall obtain documentation that the vehicle is registered in the name of the company.

The MCO shall ensure that vehicles meet the following minimum requirements:

- Windshield in good condition and free of vision impairments;
- Active LA inspection sticker or, if applicable, the inspection sticker for vehicles operating in Orleans and Jefferson Parish;
- Certificate of Public Necessity and Convenience (CPNC) for each vehicle operating in New Orleans and NEMT permit for each vehicle operating in Jefferson Parish;
- Signage on the appropriate sides of the vehicle (see *Signage*);
- License plate, with an active registration sticker;
- Vehicle Identification Number (VIN) on a portion of the vehicle;
- Registration and insurance card secured in the vehicle;
- Functioning air conditioning and heating in the front and rear of the vehicle;
- Functioning seatbelts;
- Seat belt cutter secured in the vehicle within the driver's reach;
- Fire extinguisher, showing the pressure gauge is reading within the manufacturer's optimal setting, secured in the vehicle; and
- MCO or its transportation broker's decal, displaying the date the vehicle passed inspection, attached to the vehicle.

Stretcher vans, two-door vehicles, and pickup trucks are not allowable vehicle types. Salvage title vehicles are also not allowed.

If the vehicle is equipped to transport wheelchairs, the MCO must ensure that it complies with all applicable Americans with Disabilities Act (ADA) requirements, including requirements for restraints, tie-downs, lifts, and ramps.

The MCO shall require NEMT providers to notify the MCO of any newly added vehicles in order for the MCO to properly inspect and credential the vehicle prior to use within the NEMT Program. Providers must submit copies of vehicle registration and Certificate of Insurance (COI) for all newly added vehicles. Providers operating in New Orleans or Jefferson Parish must also submit copies of their appropriate municipal or parochial permits.

Signage

Each vehicle must have signage that displays the name and the telephone number of the enrolled provider and the vehicle number. The signage must be located on the driver side, passenger side, and, if a van, on the rear of the vehicle. Signs must not be affixed to the windows where they would interfere with the vision of the driver.

Vehicles funded by the Louisiana Department of Transportation and Development (DOTD) are required to have the DOTD transit logo displayed on them. This logo will be accepted as appropriate signage for enrollment in the NEMT program.

Vehicles operating in Orleans Parish must use their Orleans Parish Certificate of Public Necessity and Convenience (CPNC) number as their vehicle number. The CPNC number must meet Orleans Parish regulations for size, contrast of color, and location.

License Plates

Each NEMT vehicle must have a "for hire", "public", or "public handicapped" license plate, in accordance with La. R.S. 45:181 and 49:121. The vehicle must be licensed in the provider's business name when obtaining the license plate.

Vehicle Inspections

The MCO must perform an inspection prior to the vehicle being placed into the NEMT Program and annually thereafter.

The inspection must ensure that the vehicle meets all items covered under the Louisiana Highway Regulatory Act and functions as intended by the manufacturer.

Vehicle inspections shall be documented electronically and include digitized photographs evidencing that requirements have been met, including, but not limited to:

- Each side of the vehicle and appropriate signage;
- LA inspection sticker which should also include the vehicle VIN;
- Clear and legible license plate, registration sticker, VIN, and registration and insurance cards;
- Location of the seat belt cutter and fire extinguisher, including a pressure gauge reading;
- Active use of a temperature gun directed at a vent measuring the temperature of the air conditioning/heating of the front vent and rear vent, when one is present, of the vehicle. The reading should be no hotter than 52 degrees Fahrenheit when measuring the air conditioning nor cooler than 100 degrees Fahrenheit when measuring the heater;
- Interior of the vehicle showing all seat belts secured properly; and
- The MCO's decal, displaying the date the vehicle passed inspection, attached to the vehicle.

If the vehicle is equipped to transport wheelchairs, the inspector shall ensure that the wheelchair lift and all backup mechanisms are in working order. Digital photographs of the following are also required:

- Wheelchair secured showing proper application of the securements to the base; and
- Wheelchair shoulder and lap belt properly secured with the wheelchair in frame for reference.

All vehicle identifying information must be captured during the inspection to include VIN, year, make, model, vehicle color, license plate number, date of inspection, name and signature of inspector, and inspection results.

Unannounced Compliance Reviews

In an ongoing effort to identify and remedy non-compliant behavior, LDH or the MCO may perform unannounced vehicle compliance reviews. During these reviews, providers may be monitored for driver, vehicle, and program compliance which includes, but is not limited to, the examination of all provider manifests, signature pages, drivers' licenses, vehicle registration, insurance cards, vehicle safety checks, etc. Non-compliance with any of the aforementioned may result in sanctions, suspension, and/or exclusion from the LA Medicaid Program. Providers do NOT have the right to refuse an unannounced compliance review.

Provider Responsibilities

The MCO shall ensure that transportation providers comply with the following provider responsibilities.

Travel and Wait Times

Transportation providers must perform services in a timely and professional manner. The MCO shall ensure that providers meet the following standards:

- Enrollees must arrive at least 15 minutes, but no more than two hours, prior to their appointments;
- Enrollees shall be picked up no more than two hours after the appointment has concluded; and
- Enrollees shall not be in the vehicle for more than one hour beyond the estimated travel time.

Vehicle Operation Requirements, Safety, and Professionalism

The MCO shall ensure that drivers project responsible, professional, and courteous behavior by monitoring compliance of the following requirements.

Drivers must **exercise the utmost safety** in caring for enrollees while transporting them and guard against becoming insensitive to their physical and emotional conditions.

Drivers must ensure:

- The equipment and vehicle used are kept clean and serviceable at all times;
- All laws of the State of Louisiana are observed while transporting passengers; and
- The vehicle is safe and in good operating condition.

NOTE: A vehicle must not be driven unless the driver determines that the following parts and accessories are in good working order: vehicle brakes, parking brakes, steering mechanism, lighting devices and reflectors, tires, horn, windshield wipers, and mirrors.

Drivers must:

- Not use or be under the influence of alcohol within four hours before going on duty or while operating, or having physical control of, a vehicle.
- Not be under the influence of an amphetamine of any formulation thereof, a narcotic drug or any derivative thereof, or other substance to a degree which renders the driver incapable of safely operating a vehicle.
- Come to a complete stop at all railroad crossings.

- ❖ Utilize the proper procedures required to move enrollees into and out of the vehicle equipped to transport non-ambulatory, wheelchair enrollees.
- ❖ Ensure that all passengers are wearing seatbelts or are otherwise secured. If the passenger uses a wheelchair during transport, the driver must ensure the appropriate use of an occupant restraint system. Lap positioning belts and chest straps are not sufficient safety restraints for wheelchair passengers.
- ❖ Ensure that no smoking or vaping occurs in the vehicle as in accordance with current Occupational, Safety and Health Administration (OSHA) regulations.
- ❖ Always turn the engine off when fueling a motor vehicle, and never fuel the vehicle where there is smoke or an open flame.
- ❖ Ensure that vehicles are not towed or pushed with passengers on board.

Drivers shall ensure the proper installation and usage of the child passenger restraint systems in compliance with La. R.S. 32:295. Non-compliance with these laws may result in immediate suspension of the driver and/or provider.

Emergency Action Procedure

If an emergency arises while transporting an enrollee, the driver must immediately assess the situation and determine whether to:

- ❖ Stop the vehicle and assist with the emergency;
- ❖ Proceed immediately to the nearest medical facility; or
- ❖ Call 911 for emergency medical assistance.

If the enrollee is taken to an emergency medical facility, the driver must immediately notify the MCO or its transportation broker and a member of the enrollee's family. When driving to the emergency medical facility, the driver should remain calm and alert and drive as quickly as conditions permit for safe vehicle operation.

Incident Reporting Requirements

Drivers who are involved in an incident shall notify emergency services immediately and in accordance with La. R.S. 32:398.

The transportation provider must report the following to the MCO:

Reporting Requirements	Reporting Period
For all motor vehicle accidents: • Time, date, location, and summary of incident; • Provider name; • Driver and vehicle information; • Enrollee name, Medicaid ID number, and contact information; • Name and contact information for all other passengers; • Injuries sustained; • Names and contact information of witnesses; • Any police issued citations or summons; and • Results of drug screen which was conducted within 12 hours of the incident.	Within 72 hours of the accident

Copy of the Louisiana Uniform Motor Vehicle Accident Report	Within 15 business days of the accident
Written report of all incidents when a Medicaid enrollee dies or is injured while in the provider's care, regardless of the cause	Within 72 hours of the incident

If the MCO contracts with a transportation broker, the transportation broker shall provide a detailed accounting of each incident to the MCO upon notification by the provider.

Record Keeping

The MCO shall require transportation providers to maintain sufficient documentation to identify the enrollees transported, trips made, locations traveled, driver qualifications, vehicle capabilities, and safety information.

Daily Trip Log

The MCO shall obtain a daily trip log from profit and non-profit transportation providers that captures the following information:

- Trip identification number;
- Enrollee's name, Medicaid ID number, address, and signature;
- Destination address;
- Healthcare provider or facility's name, if applicable;
- Departure date and time;
- Arrival date and time;
- Driver's name;
- VIN; and
- Any other comments regarding the trip.

The daily trip log shall be maintained in electronic format and sorted chronologically.

Prior to reimbursement, the MCO shall verify that each claim from a profit or non-profit transportation provider has a corresponding entry in the daily trip log.

Gas Reimbursement Form

The MCO shall obtain a gas reimbursement form for **every** NEMT claim from a gas reimbursement provider to be eligible for reimbursement. The gas reimbursement form must be typed or written in ink and include the following information:

- Trip identification number;
- Driver's full name;
- Driver's residential address;
- Driver's phone number;
- Driver's email address (if applicable);
- Driver's relationship to enrollee;
- Enrollee's name;

- Enrollee's Medicaid ID number;
- Enrollee's address;
- Transportation date;
- Name of facility/medical provider;
- Address of facility/medical provider;
- Phone number of facility/medical provider;
- Signature of driver attesting that the information on the form is true and correct;
- Signature of enrollee or parent/guardian attesting that the information on the form is true and correct;
- Medical facility/physician's signature and date; and
- Medical facility's stamp.

Prior to reimbursement, the MCO shall verify that each claim from a gas reimbursement provider has a corresponding and properly completed gas reimbursement form.

Claims and Encounters

Claims Filing

Transportation providers shall submit all transportation claims to the MCO. Claims shall be submitted within 365 days of the date of service.

The MCO shall maintain a system that accepts electronic claim submissions and may not require providers to submit paper claims.

Encounter Submissions

The MCO shall submit encounters in compliance with the contract and the **MCO System Companion Guide**.

The MCO shall submit encounters for bus passes (e.g., daily pass, monthly pass) using procedure code A0110.

The MCO shall flag value-added benefits in accordance with the **MCO System Companion Guide**.

Ambulance

Ambulance transportation is emergency or non-emergency medical transportation provided to Medicaid enrollees to and/or from a Medicaid provider for a medically necessary Medicaid covered service when the enrollee's condition is such that use of any other method of transportation is contraindicated or would make the enrollee susceptible to injury. The MCO shall not cover ambulance services when another means of transportation could be utilized without endangering the individual's health.

To participate in the Medicaid program, ambulance providers must meet the requirements of La. R.S. 40:1135.3. Licensing by the LDH Bureau of Emergency Medical Services is also required. Services must be provided in accordance with state law and regulations governing the administration of these services. Additionally, licensure is required for the medical technicians and other ambulance personnel by the LDH Bureau of Emergency Medical Services.

Reimbursement to ambulance providers shall be no less than the published Medicaid FFS rate in effect on the date of service, unless mutually agreed upon by the MCO or its transportation broker and the transportation provider in the provider agreement.

Terms utilized in the published Medicaid fee schedule are defined as follows:

- ***Basic Life Support (BLS)***[5]: Emergency medical care administered to the EMT-basic scope of practice.
- ***Advanced Life Support (ALS)***[6]: Emergency medical care administered to at least the level of an emergency medical technician-paramedic's scope of practice.
- ***Specialty Care Transport***[7]: Interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic.

The MCO shall reimburse ambulance providers for mileage to the nearest appropriate facility. Reimbursement for mileage will vary depending on whether the transport is for an emergency or non-emergency event. Reimbursement for mileage shall be limited to actual mileage from point of pick up to point of delivery. Mileage can only be reimbursed for miles traveled with the enrollee in the ambulance.

Refer to the *Hospital Services* section of this Manual for policies related to hospital-based ambulance services.

Emergency Ambulance Transportation

Emergency ambulance transportation is provided for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the enrollee (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

An enrollee may also require emergency ambulance transportation if he or she is psychiatrically unmanageable or needs restraint.

The MCO shall ensure that ambulance providers retain documentation that appropriately supports that at least one of these criteria was met and that the enrollee would be susceptible to injury using any other method of transportation. An ambulance trip that does not meet at least one of these criteria would be considered a nonemergency service and must be coded and billed as such.

The MCO may not require prior review or authorization for emergency ambulance transportation.

The MCO shall reimburse for oxygen and disposable supplies separately when medically necessary.

[5] Defined by *Louisiana Administrative Code*, Title 48, Part I, Section 6001.
[6] Defined by *Louisiana Administrative Code*, Title 48, Part I, Section 6001. Refer to 42 C.F.R. §414.605 for the distinction between ALS levels 1 and 2.
[7] Defined by 42 C.F.R. §414.605.

Ambulance Treatment in Place

Ambulance providers that are dispatched by an emergent call for service may determine upon the scene that a telehealth visit with a licensed medical professional, who is enrolled in Medicaid, is more appropriate than transportation to an emergency department. In this case, the treatment-in-place service may be rendered.

NOTE: Treatment in place is classified as an emergency transportation service. All provisions, including criteria and documentation to support the emergency determination, from the preceding section apply.

Both the telehealth claim and the ambulance treatment-in-place claim shall be payable by the MCO. If the ambulance provider bills on behalf of the telehealth provider, the MCO shall ensure that the ambulance provider bills the telehealth service separately from the treatment-in-place service and in accordance with the requirements below.

Ambulance Telemedicine/Telehealth Claims

The ambulance provider's NPI must be enrolled in Medicaid as a Professional Service (claim type 04) billing provider.

The rendering provider's NPI must be reported on the claim and enrolled in Medicaid as a licensed physician, physician assistant, or advanced practice registered nurse.

The claim must indicate place of service 02 and modifier 95.

Approved telemedicine/telehealth procedure codes for ambulance telemedicine/telehealth claims are listed in the following table:

Category	Service	CPT Codes
Evaluation and Management, Office or Other Outpatient Service	New Patient	99201, 99202, 99203, 99204, 99205
	Established Patient	99211, 99212, 99213, 99214, 99215

Ambulance Treatment in Place Claim

The ambulance provider's NPI must be enrolled in Medicaid as an Ambulance Service (claim type 07) billing provider.

Supply codes A0382 and A0398 are payable, but mileage (A0425) and other ambulance transportation services are not payable. Claims billed with non-payable ambulance treatment in place services shall be denied.

Claims must indicate treatment in place destination code "W" in the destination position of the origin/destination modifier combination.

Valid ambulance claim modifiers for treatment in place are listed in the following table:

Modifier	Origination Site	Destination
DW	Diagnostic or therapeutic site other than P or H when these are used as origin codes	Tx-in-Place
EW	Residential, domiciliary, custodial facility (other than 1819 facility)	Tx-in-Place
GW	Hospital based ESRD facility	Tx-in-Place
HW	Hospital	Tx-in-Place

IW	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport	Tx-in-Place
JW	Freestanding ESRD facility	Tx-in-Place
NW	Skilled nursing facility	Tx-in-Place
PW	Physician's office	Tx-in-Place
RW	Residence	Tx-in-Place
SW	Scene of accident or acute event	Tx-in-Place

Emergency Transportation to Hospital During Treatment in Place

If the enrollee being treated in place has a real time deterioration in his or her clinical condition which necessitates immediate transport to an emergency department, the ambulance provider shall transport the enrollee if appropriate.

In no instance may the MCO reimburse for both an emergency transport to a hospital and an ambulance treatment-in-place service for the same incident.

Exclusions

Medicaid does not cover "Ambulance 911-Non-emergency" services (i.e., procedure code A0226). If the enrollee's medical condition does not present itself as an emergency in accordance with the criteria in this manual, the service may be considered a non-covered service by Medicaid.

The MCO may allow ambulance providers to bill enrollees for non-covered services only if the enrollee was informed prior to transportation, verbally and in writing, that the service was not covered by Medicaid and the enrollee agreed to accept the responsibility for payment. The MCO shall ensure that the provider obtains a signed statement or form which documents that the enrollee was verbally informed of the out-of-pocket expense.

Non-Emergency Ambulance Transportation

Non-emergency ambulance transportation (NEAT) is provided to a Medicaid enrollee to and/or from a provider of medical services for a covered medical service when no other means of transportation is available and the enrollee is unable to ride in any other type of vehicle due to medical reasons. The nature of the trip is not an emergency, but the enrollee requires the use of an ambulance.

The enrollee's treating physician, a registered nurse, the director of nursing at a nursing facility, a nurse practitioner, a physician assistant, or a clinical nurse specialist must certify on the Certification of Ambulance Transportation (CAT) that the transport is medically necessary and describe the medical condition which necessitates ambulance services. The certifying authority shall complete the date range on the CAT, which shall be no more than 180 days. A single CAT should be utilized by the MCO for all of the enrollee's transports within the specified date range. The MCO may not require a new CAT from the certifying authority for the same enrollee during this date range.

NEAT must be scheduled by the enrollee or a medical facility through the MCO or the ambulance provider.

- If transportation is scheduled *through the MCO*, the MCO shall verify, prior to scheduling, enrollee eligibility, that the originating or destination address belongs to a medical facility, and that a completed Certification of Ambulance Transportation form is received for the date of service. Once the trip has been

dispatched to an ambulance provider and completed, the ambulance provider shall be reimbursed upon submission of the clean claim for the transport.

- If transportation is scheduled *through the ambulance provider*, the MCO shall require the ambulance provider to verify enrollee eligibility, that the originating or destination address belongs to a medical facility, and that a completed Certification of Ambulance Transportation form is received for the date of service. The MCO shall reimburse the ambulance provider only if a completed Certification of Ambulance Transportation form is submitted with the clean claim or is on file with the MCO or its transportation broker prior to reimbursement.

Mileage must be reimbursed in accordance with the type of service indicated by the licensed medical professional on the Certification of Ambulance Transportation.

The Certification of Ambulance Transportation form is located at www.lamedicaid.com [link].

Nursing Facility Ambulance Transportation

Nursing facilities are required to provide medically necessary transportation services for Medicaid enrollees residing in their facilities. Any nursing facility enrollee needing non-emergency, non-ambulance transportation services are the financial responsibility of the nursing facility. NEAT services provided to a nursing facility enrollee must include the Certification of Ambulance Transportation to be reimbursable by the MCO; otherwise, the nursing facility shall be responsible for reimbursement for such services.

Air Ambulance

Air ambulances may be used for emergency and non-emergency ambulance transportation when medically necessary. Licensure by the LDH Bureau of Emergency Medical Services is also required. Licensure for air ambulance services is governed by La. R.S. 40:1135.8. Rotor winged (helicopters) and fixed winged emergency aircraft must be certified by BHSF in order to receive Medicaid reimbursement.

All air ambulance services must comply with state laws and regulations governing the personnel certifications of the emergency medical technicians, registered nurses, respiratory care technicians, physicians, and pilots as administered by the appropriate agency of competent jurisdiction.

The MCO shall cover air ambulance services only if:

- Speedy admission of the enrollee is essential and the point of pick-up of the enrollee is inaccessible by a land vehicle; or
- Great distances or other obstacles are involved in getting the enrollee to the nearest hospital with appropriate services.

If both land and air ambulance transport are necessary during the same trip, the MCO shall reimburse each type of provider separately according to regulations for that type of provider.

Ambulance Memberships

The MCO shall prohibit ambulance companies that are enrolled in Medicaid from soliciting Medicaid enrollees for membership fees for a subscription plan. Solicitation of such fees is a violation of Section 1916 of the Social

Security Act and regulations at 42 C.F.R. §§ 447.15 and 447.56. If such membership fees are collected, the Medicaid enrollee must be refunded in full, or the ambulance provider will be terminated from the program.

It is not a violation of the regulations when a Medicaid-enrolled ambulance company accepts membership fees if the Medicaid enrollee voluntarily subscribes to the plan.

If a Medicaid-enrolled ambulance company's subscription plan operates as an insurance policy, and the Medicaid enrollee pays the fee, the fee is treated as an insurance premium and is not in violation of Medicaid regulations.

Return Trips and Transfers

Return Trips

When an enrollee is transported to a hospital by ambulance on an emergency basis and is not admitted, the hospital shall request an NEMT return trip with the MCO unless the enrollee meets the medical necessity requirements for NEAT.

Transfers

An ambulance transfer is the transport of an enrollee by ambulance from one hospital to another. The MCO shall only cover ambulance transfers when it is medically necessary for the enrollee to be transported by ambulance. The enrollee must be transported to the most appropriate hospital that can meet his or her needs.

If the physician makes the decision that the level of care required by the enrollee cannot be provided by the hospital, and the enrollee has to be transported by the provider to another hospital, the MCO shall reimburse the transportation provider for both transfers once clean claims are submitted for the transfers.

Claims and Encounters

Claims Filing

Ambulance providers shall submit claims using the CMS 1500 Health Insurance Claim Form (paper) or the 837P (electronic).

Ambulance providers shall submit claims for ambulance transportation to the MCO.

Claims shall be submitted within 365 days of the date of service.

Medicaid and Medicare Part B

Services for Medicare Part B enrollees should be billed to the Medicare carrier on the Medicare claim form. Medicare will make payment and cross the claim over to the MCO for Title XIX payment.

Medicaid will not make payment on any claim denied by Medicare as not being medically necessary. Qualified Medicare Beneficiary (QMB) claims are included in this policy.

For trips that are not covered by Medicare but are covered by Medicaid, payment will not be made unless the claim is filed with the Medicare EOB attached stating the reason for denial by Medicare.

For claims that fail to cross over electronically, a hard-copy claim may be filed up to six months after the date of the Medicare EOB, provided that the claim was filed with Medicare within a year of the date of service.

Medicaid does a cost comparison of cross-over claims to determine if Medicare paid more than Medicaid for the claim. If this occurs and Medicare has paid more than Medicaid reimburses for the service, the claim will be "zero" paid and the ambulance provider will be considered paid in full. No balance may be collected from the enrollee.

Ambulance Transportation Modifiers

When billing for procedure codes A0425-A0429 and A0433-A0434 for ambulance transportation services, the MCO shall require the provider to also enter a valid 2-digit modifier at the end of the associated 5-digit procedure code. Different modifiers may be used for the same procedure code. Spaces will not be recognized as a valid modifier for those procedures requiring a modifier. The following table identifies the valid modifiers.

Modifier	Description
DD	Trip from DX/Therapeutic Site to another DX/Therapeutic Site
DE	Trip from DX/Therapeutic Site to Residential, Domiciliary, Custodial Facility
DH	Trip from DX/Therapeutic Site to Hospital
DI	Diagnostic-Therapeutic Site/Transfer Airport Heli Pad
DP	Trip from DX/Therapeutic Site to Physician's Office
DR	Trip from DX/Therapeutic Site to Home
DX	Trip from DX/Therapeutic Site to MD to Hospital
ED	Trip from an RDC or Nursing home to DX/Therapeutic Site
EH	Trip from an RDC or Nursing home to Hospital
EG	Trip from an RDC or Nursing home to Dialysis Facility (Hospital based)
EI	Residential Domicile Custody Facility/Transfer Airport Heli Pad
EJ	Trip from an RDC or Nursing home to Dialysis Facility (non-Hospital based)
EN	Trip from an RDC or Nursing home to SNF
EP	Trip from an RDC or Nursing home to Physician's Office
ER	Trip from an RDC or Nursing home to Physician's Office
EX	Trip from RDC to MD to Hospital
GE	Trip from HB Dialysis Facility to an RDC or Nursing Home
GG	Trip from HB Dialysis Facility to Dialysis Facility (Hospital Based)
GH	Trip from HB Dialysis Facility to Hospital
GI	HB Dialysis Facility/Transfer Airport Heli Pad

Modifier	Description
GJ	Trip from HB Dialysis Facility to Dialysis Facility (non-Hospital Based)
GN	Trip from HB Dialysis Facility to SNF
GP	Trip from HB Dialysis Facility to Physician's Office
GR	Trip from HB Dialysis Facility to Patient's Residence
GX	Trip from HB Dialysis Facility to MD to Hospital
HD	Trip from Hospital to DX/Therapeutic Site
HE	Trip from Hospital to an RDC or Nursing Home
HG	Trip from Hospital to Dialysis Facility (Hospital Based)
HH	Trip from One Hospital to Another Hospital
HI	Hospital/Transfer Airport Heli Pad
HJ	Trip from Hospital to Dialysis Facility
HN	Trip from Hospital SNF
HP	Trip from Hospital to Physician's Office
HR	Trip from Hospital to Patient's Residence
IH	Transfer Airport Heli Pad/Hospital
JE	Trip from NHB Dialysis Facility to RDC or Nursing Home
JG	Trip from NHB Dialysis Facility to Dialysis Facility (Hospital Based)
JH	Trip from NHB Dialysis Facility to Hospital
JI	NHB Dialysis Facility/Transfer Airport Heli Pad
JN	Trip from NHB Dialysis Facility to SNF
JP	Trip from NHB Dialysis Facility to Physician's Office
JR	Trip from NHB Dialysis Facility to Patient's Residence
JX	Trip from NHB Dialysis Facility to MD to Hospital
ND	Trip from SNF to DX/Therapeutic Site
NE	Trip from SNF to an RDC or Nursing Home
NG	Trip from SNF to Dialysis Facility (Hospital based)
NH	Trip from SNF to Hospital
NI	Skilled Nursing Facility/Transfer Airport Heli Pad
NJ	Trip from SNF to Dialysis Facility (non-Hospital based)
NN	Trip from SNF to SNF

Modifier	Description
NP	Trip from SNF to Physician's Office
NR	Trip from SNF to Patient's Residence
NX	Trip from SNF to MD to Hospital
PD	Trip from a Physician's Office to DX/Therapeutic Site
PE	Trip from a Physician's Office to an RDC or Nursing Home
PG	Trip from a Physician's Office to Dialysis Facility (Hospital based)
PH	Trip from a Physician's Office to a Hospital
PI	Physician's Office/Transfer Airport Heli Pad
PJ	Trip from a Physician's Office to Dialysis Facility (non-Hospital based)
PN	Ambulance trip from the Physician's Office to Skilled Nursing Facility
PP	Ambulance trip from Physician to Physician's Office
PR	Trip from Physician's Office to Patient's Residence
RD	Trip from the Patient's Residence to DX/Therapeutic Site
RE	Trip from the Patient's Residence to an RDC or Nursing Home
RG	Trip from the Patient's Residence to Dialysis Facility (Hospital based)
RH	Trip from the Patient's Residence to a Hospital
RI	Residence/Transfer Airport Heli Pad
RJ	Trip from the Patient's Residence to Dialysis Facility (non-Hospital based)
RN	Trip from the Patient's Residence to Skilled Nursing Facility
RP	Trip from the Patient's Residence to a Physician's Office
RX	Trip from Patient's Residence to MD to Hospital
SH	Trip from the Scene of an Accident to a Hospital
SI	Accident Scene, Acute Event/Transfer Airport, Heli Pad
TN	Rural Area (for rotary wing emergency air ambulance trips only)

Medicare Non-Covered Transportation Modifiers

The MCO shall require the following modifiers to be used when billing for transports that are non-covered services by Medicare. These modifiers may be used ONLY with procedure codes A0425-A0429 and A0433-A0434 to allow the claim to bypass the Medicare edit and process as a Medicaid claim.

Modifier	*Description*
DD	Clinic/Free-standing Facility to Clinic/Free-standing Facility
DE	Clinic/Free-standing Facility to Nursing Home
DP	Clinic/Free-standing Facility to Physician
DR	Clinic/Free-standing Facility to Residence
ED	Nursing Home to Clinic/Free-standing Facility
EP	Nursing Home to Physician *
ER	Nursing Home to Residence
HP	Hospital to Physician
NP	Skilled Nursing Facility to Physician *
PD	Physician to Clinic/Free-standing Facility
PE	Physician to Nursing Home
PN	Physician to Skilled Nursing Facility
PP	Physician to Physician
PR	Physician to Residence
RD	Residence to Clinic/Free-standing Facility
RE	Residence to Nursing Home
RP	Residence to Physician *

* These modifiers will bypass the Medicare edit for non-emergency transports ONLY.

Encounter Submissions

The MCO shall submit encounters in compliance with the contract and the **MCO System Companion Guide**.

Record Retention

All documentation, data, and/or records of the MCO and transportation broker related to the provision of medical transportation services shall be retained for at least ten years, or longer if those records are subject to review, audit, or investigation or subject to an administrative or judicial action brought by or on behalf of the state or federal government. Under no circumstances shall such records be destroyed or disposed of, even after the expiration of the mandatory ten-year retention period, without the express prior written permission of LDH.

PERSONAL CARE SERVICES

The MCO shall comply with the Personal Care Services Provider Manual and Specialized Behavioral Health Provider Manual chapters of the **Medicaid Services Manual** and the additional requirements below.

Electronic Visit Verification for EPSDT PCS and Behavioral Health PCS

The Louisiana Service Reporting Systems (LaSRS) is LDH's electronic visit verification (EVV) system for providers of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) personal care services (PCS) and behavioral health personal care services. Utilization of an EVV system is a federal requirement that applies to all managed care PCS providers.

In accordance with the 21st Century Cures Act, LDH collects the following identifiable information for Home and Community-Based Services (HCBS) waiver and Louisiana Medicaid State Plan services through LaSRS:

- The type of service performed;
- The enrollee receiving the service;
- The date of the service;
- The location of service delivery;
- The individual providing the service; and
- The time the service begins and ends.

LaSRS does not "track" direct service workers—it only collects the location of service delivery at the time of clock-in and clock-out. LaSRS can be accessed by devices with internet connectivity (e.g., computer, smartphone, tablet). When a worker "clocks in" or "clocks out", the system collects the location of the device being used at that time, as well as the time, date, individual providing the service, and the individual receiving the service. The intent of this system is to ensure that enrollees receive services authorized in their plans of care, reduce inappropriate billing/payment, safeguard against fraud, replace paper timesheets, and improve program oversight.

The MCO must require its PCS providers to use LaSRS. The MCO must withhold or deny reimbursement for services if a PCS provider fails to use the EVV system as directed by LDH.

PHARMACY

The MCO shall cover all medically necessary prescription medicines on the Covered Drug List (CDL). The MCO may also cover additional pharmacy benefits, such as vaccines, diabetic supplies, and compounded drugs.

The MCO shall not cover the following excluded drugs:

- Agents when used for anorexia, weight loss, or weight gain, except orlistat.
- Agents when used to promote fertility, except vaginal progesterone when used for high-risk pregnancy to prevent premature births.
- Agents when used for symptomatic relief of cough and colds, except for antihistamine and antihistamine/decongestant combination products.

The MCO shall cover the following drugs, with restrictions:

- Agents used for cosmetic purposes or hair growth only when medical necessity has been determined.
- Select drugs for erectile dysfunction, except when used for the treatment of conditions or indications other than erectile dysfunction as approved by the FDA.

The MCO shall cover a minimum of four prescriptions per calendar month. However, it may not enact prescription limits more stringent than those in the Louisiana Medicaid State Plan. If prescription limits are enacted, the MCO shall have Point of Sale (POS) override capabilities when a greater number of prescriptions per calendar month are determined to be medically necessary by the prescriber.

Except for the use of LDH-approved generic drug substitution of branded drugs, under no circumstances shall the MCO permit the therapeutic substitution of a prescribed drug without a prescriber's authorization.

The MCO shall refer to the Contract for requirements related to the CDL, including the Preferred Drug List (PDL) and Non-Preferred Drug List (NPDL).

Brand Name and Generic Drugs

Claims for multi-source "Brand Name Products" that are not included in the PDL/NPDL process (i.e., drugs not listed on the Preferred Drug List on the static link), shall not be subject to prior authorization. Since the manufacturers of these brand name products have signed the federal rebate agreement, these drugs must have a potential payable status. In consideration of the mandatory generic substitution, LDH requires the MCOs/PBMs to allow dispense as written (DAW) codes "1", "5", "8", and "9" for brand name processing. LDH expects the following codes to accommodate the filling of a brand name product without use of prior authorization:

- DAW "1": Brand name medically necessary from prescriber.
- DAW "5": Substitution allowed-brand drug dispensed as a generic (should be allowed when the brand drug is less expensive for 340B providers).
- DAW "8": Substitution allowed, generic drug not available in marketplace.
- DAW "9": Preferred brand over generic drugs.

Denials of brand drugs (unless the brand is a preferred drug—in or out of the process) should deny with an error code stating "generic substitution required", mapped to NCPDP 22 (M/I Dispense as written (DAW)/Product selection code).

Drug Utilization Review Program

The MCO shall maintain a Drug Utilization Review (DUR) program in accordance with the Contract and the CMS Managed Care Final Rule (CMS-2390-F). The Prospective DUR Program, Retrospective DUR Program, and Educational DUR Program standards implemented by the MCO shall be consistent with the standards established by LDH in the Contract. The MCOs and Medicaid FFS will implement new and revised DUR criteria as voted on by the Medicaid DUR Board. LDH will send the MCO the approved new and revised MCO-specific DUR criteria, and the MCO shall implement within the time period established by LDH.

Any revisions to the MCO's DUR policy and procedures or utilization review process/procedure and included standards shall be approved by LDH prior to implementation. At a minimum, the MCO DUR programs shall include all Medicaid DUR Board initiatives and shall submit any new initiatives to LDH that it would like to include on the Medicaid DUR Board agenda at least 45 days in advance of the DUR Board meeting.

The MCO shall provide a detailed description of its DUR program annually to LDH to comply with CMS DUR annual reporting requirements as per the Managed Care Final Rule. The annual report to the state will be due six weeks after LDH sends the CMS template to the MCOs. The MCO shall be responsible for developing responses to any

questions posed by CMS on the annual report and for coordinating its response through LDH. MCOs are required to program their claims processing systems to capture claim level data that is required by CMS for incorporation into the DUR Annual Report.

The MCO DUR program shall contain the following components:

Prospective DUR Program

Prospective DUR Program requirements are provided in the Contract. Additional guidance is provided below.

Each inappropriate therapy edit identified through the Prospective DUR Program shall be coded with an individual denial description, which shall be reported separately.

Some DUR prospective criteria will allow for a soft edit or a pharmacist override. MCOs shall align National Council for Prescription Drug Programs (NCPDP) compliant POS edits and overrides. When the pharmacist receives a prospective DUR alert message that requires a pharmacist's review, the MCO POS system shall have the capability to allow the pharmacist to override the alert using the appropriate NCPDP "conflict, intervention and outcome" codes or other NCPDP compliant PA/MC[8] override. POS overrides shall be implemented upon LDH direction. The MCO shall identify the top 10 pharmacies that have the most edit overrides and report them on the revised monthly DUR report (RX162).

Denial of pharmacy claims could be triggered by an inappropriate diagnosis code or the absence of a diagnosis code, depending on the Medicaid DUR Board approved criteria. Diagnosis codes shall be supplied by the prescriber on the prescription or transmitted verbally from the prescriber's office to the pharmacist. The pharmacist shall enter the diagnosis code at POS in NCPDP field 424-DO (diagnosis code).

MCO reporting, in accordance with the new CMS Managed Care Final Rule, shall include but not be limited to, the following:

Top drug claims data reviewed by the DUR Board (See Table 1 in FFS DUR Annual Report [link]):

1. Top 10 prior authorization (PA) requests by drug name;
2. Top 10 PA requests by drug class;
3. Top five claim denial reasons other than eligibility (e.g., quantity limits, early refill, PA, therapeutic duplications, age limits);
4. Top 10 drug names by amount paid;
5. From data in number 4, a determination of the percentage of total drug expenditures;
6. Top 10 drug names by claim count; and
7. From data in number 6, a determination of the percentage of total claims represented by the top 10 drugs.

The MCO shall comply with all final reporting requirements and/or templates produced by CMS.

[8] Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. Information about the specific medical condition was provided by the prescriber, patient, or pharmacist.

Retrospective DUR Program

Retrospective DUR (RetroDUR) Program requirements are provided in the Contract. Additional guidelines are provided below.

At a minimum, the MCO shall implement all of the DUR Board approved retrospective initiatives. An implementation timeline for retrospective interventions will be coordinated through LDH. Retrospective interventions are defined as communication from the MCO through intervention letters to the provider when DUR criteria are met.

Intervention letters, including enrollee profiles, shall be sent to selected prescribers and/or pharmacy providers and include the following:

- Cover sheet (template will be provided by LDH);
- Response sheet (template will be provided by LDH);
- Additional enclosures, if applicable (examples include recommendations and supportive clinical guidelines if not included in cover sheet); and
- Enrollee profile. In order to display drug utilization patterns, the MCO shall generate enrollee profiles to send to the prescriber and/or pharmacy provider.
    - Enrollee profiles shall be composed of the following elements:
        - Enrollee information – name, Medicaid ID, date of birth, and gender – should be included in the header on every page;
        - Prescription claim information, including drug name; National Drug Code (NDC); prescription number; diagnosis (if provided); date of service; quantity dispensed; days' supply; pharmacy information such as name, address, and National Provider Identifier (NPI) number; and prescriber information (name, address, NPI);
        - Physician administered drugs (currently optional); and
        - Exception criteria and description should be displayed at the beginning of the enrollee profile (e.g., 1-Famotidine: exceeds maximum recommended dose (80 mg/day); 2-Contraindication: dorzolamide/timolol ophthalmic for patient with asthma; 3-Possibility of patient non-compliance with anti-diabetes therapy).
    - Enrollee profiles shall exclude line items that contain any substance use disorder (SUD) diagnosis, drugs, and providers (such as clinicians, prescribers, and facilities) who solely treat SUD. See Code of Federal Regulations, Title 42, Chapter I, Subchapter A, Part 1 [link].

To determine if intervention letters are necessary, the MCO shall have a clinician, or a team of clinicians, evaluate the enrollee profile before sending the intervention letter. Clinicians shall be pharmacists, nurses, or physicians. The clinician must be familiar with current clinical guidelines. The purpose is to send only meaningful information to the prescriber/pharmacist that will enable them to improve the enrollee's care.

The MCO shall track and report prescriber/pharmacist responses to intervention letters through standing reporting established by LDH. Reporting shall include, but not be limited to, the following for the DUR annual report to CMS:

- Retrospective DUR Educational Outreach Summary. Rank of the top 10 interventions: number of hits (numerator)/number of claims (denominator). This is a year-end summary report on RetroDUR screening

and educational interventions. The year-end summary reports should be limited to the top 10 problems with the largest number of exceptions including the results of RetroDUR screening and interventions.

- Summary of Medicaid DUR Board Activities. LDH or its fiscal intermediary will supply this information to the MCO for inclusion in its CMS annual report. Separately, the MCO shall include additional MCO-initiated activities which have been approved by LDH.
- Generic Drug Substitution Policies. The description of policies that may affect generic utilization percentage.
- Generic Drug Utilization Data. This includes the number of generic claims, total number of claims, and generic utilization percentage. CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each NDC along with sourcing status of each drug: S (Single Source), N (Non-Innovator Multiple-Source), or I (Innovator Multiple-Source). This file will be made available by CMS to facilitate consistent reporting across states with this data request.
- Innovative Practices. Describe in detailed narrative form any innovative practices that are believed to have improved the administration of the MCO's DUR program, the appropriateness of prescription drug use, and/or have helped to control costs (i.e., disease management, academic detailing, automated prior authorizations, continuing education programs).
- E-Prescribing Activity Summary. Describe all development and implementation plans/accomplishments in the area of e-prescribing.
- Executive Summary.

Within the LDH standing report, retrospective intervention reporting shall also include but not be limited to the following for the Medicaid DUR Board (six months after the intervention letter is sent):

- Number of enrollee profiles reviewed. This is the number of enrollee profiles reviewed by the clinician. One enrollee profile is one enrollee; one enrollee profile can have more than one intervention.
- Number of enrollee profiles with intervention letters issued. More than one provider can get a letter for the same enrollee; one letter can address more than one intervention.
- Number of responses and response rate.

Educational DUR Program

Educational DUR Program requirements are located in the Contract. MCOs shall educate prescribers, pharmacists, and enrollees on therapeutic appropriateness when overutilization or underutilization occurs and on other clinical initiatives.

Lock-In Program

The MCO shall refer to the Contract for lock-in program requirements and the **Marketing and Member Education Companion Guide** for lock-in letter templates.

Medication Therapy Management

General Requirements

The MCO shall have established a medication therapy management (MTM) program that:

- Is comprehensive and patient-centered;
- Is designed to increase medication adherence;
- Is designed to ensure that medications are appropriately used to optimize therapeutic outcomes through improved medication use;
- Is designed to reduce the risk of adverse events from medication therapy;
- May be administered by a pharmacist or other qualified providers, such as physicians, nurse practitioners, physician assistants, or nurses;
- Shall be developed in cooperation with licensed and practicing pharmacists and physicians; and
- Shall include coordination between the MCO, the enrollee, the pharmacist and the prescriber using various means of communication.

To assess the enrollee's medication therapy, the MTM program shall include an interactive comprehensive medication review (CMR), which includes enrollee discussion and prescriber intervention if needed. This results in the creation of a written summary and is followed by frequent monitoring with further interventions as needed.

Enrollment

The MCO shall enroll targeted enrollees in an opt-out method of enrollment only. This means enrollees may choose to opt-out of the program if desired at any time.

The MCO shall auto-enroll the targeted enrollees each year when they meet the eligibility criteria, and they are considered enrolled in the MTM program unless the enrollee declines enrollment. The enrolled may refuse or decline individual services without having to disenroll from the MTM program.

Targeted Enrollees

The MTM program may include enrollees with multiple chronic diseases or any specific chronic disease. If the MTM program is designed to target individual specific chronic diseases, then the program shall include at least three of the following:

- Behavioral health (such as Alzheimer's disease, bipolar disorder, depression, schizophrenia, or other chronic/disabling mental health conditions);
- Bone disease-arthritis (such as osteoporosis, osteoarthritis, or rheumatoid arthritis);
- Cardiovascular disease (such as dyslipidemia, heart failure, or hypertension);
- Diabetes;
- End-stage renal disease (ESRD);
- Hepatitis C infection;
- Respiratory disease (such as asthma, chronic obstructive pulmonary disease (COPD), or chronic lung disorders); and
- Substance use disorder.

The MCO should also offer MTM services to an expanded population of enrollees who do not meet the eligibility criteria but would benefit from MTM services. The MCO shall also leverage effective MTM to improve safety (e.g., increase adherence to medications, reduce the use of high-risk medications, and address issues of overutilization).

Required MTM Services

The MCO shall offer a minimum level of MTM services to each enrollee in the program that includes all of the following:

- Interventions for both enrollees and prescribers, as needed; and
- An annual Comprehensive Medication Review (CMR) with written summaries created in a standardized format approved by LDH; and
- Targeted Medication Reviews (TMRs), when needed, with follow-up interventions when necessary.

Comprehensive Medication Review

Comprehensive Medication Review (CMR) is a systematic process of:

- Collecting patient-specific information;
- Assessing medication therapies to identify medication-related problems;
- Developing a prioritized list of medication-related problems; and
- Creating a plan to resolve them with the patient, caregiver and/or prescriber.

The MCO shall offer a CMR to all enrollees in the MTM program at least annually.

The MCO shall offer to provide a CMR to newly targeted enrollees as soon as possible after enrollment into the MTM program, but no later than 60 days after being enrolled in the MTM program.

The enrollee's CMR shall be conducted using an interactive, person-to-person review (including prescriptions, over-the-counter medications, herbal therapies and dietary supplements) performed by a pharmacist or other qualified provider, and may result in a recommended medication action plan.

A written summary of the results of the review shall be provided to the targeted individual(s) in a standardized format approved by LDH and shall include the following:

- Any concerns the enrollee may have regarding their drug therapy;
- Purpose and instructions for use of the enrollee's medications; and
- Personal medication list (including prescription, non-prescription drugs, and supplements) which will aid in assessing medication therapy and engaging the enrollee in management of his or her drug therapy.

The MCO shall encourage enrollees to take their action plan and personal medication list from their CMR to any medical encounter (e.g., physician visit, pharmacy, or hospital admission). This summary shall serve as a valuable tool to share information across providers and help reduce duplicate therapy and drug-drug interactions.

Targeted Medication Review

The MCO shall perform Targeted Medication Reviews (TMRs) when needed to address potential or specific medication-related problems, to assess any transition of care the enrollee may have experienced, or to monitor new, unresolved, or continued medication therapies. The findings of the TMR shall then be reviewed to determine if a follow-up intervention is needed for the enrollee or the prescriber. The MCO may determine how to tailor the follow-up intervention based on the specific needs or medication use issues of the enrollee. For example, these interventions may be person-to-person or telephonic.

Outcomes Measurement

The MCO shall have a process in place to measure, analyze, and report the outcomes of their MTM program. This process shall include whether the goals of therapy have been reached and shall capture drug therapy recommendations and resolutions made as a result of MTM recommendations. A recommendation is defined as a suggestion to take a specific course of action related to the enrollee's drug therapy. Examples of drug therapy problem recommendations made as a result of MTM services and recommendations include, but are not limited to:

- Needs additional therapy;
- Unnecessary drug therapy;
- Dosage too high;
- Dosage too low;
- Adverse drug reaction;
- Medication non-adherence;
- Initiate drug;
- Change drug (such as product in different therapeutic class, dose, dosage form, quantity, or interval);
- Discontinue or substitute drug (such as discontinue drug, generic substitution, therapeutic substitution, or formulary substitution); or
- Medication adherence.

Quarterly Reporting Requirements

Reporting is an important factor in determining the effectiveness of an MTM program. The MCO shall document interventions, contact attempts, number of enrollees enrolled, and other associated parameters. Report requirements include, but are not limited to the following:

- Enrollee enrollment parameters;
- Number of contact encounters and contact-related outcomes;
- Number of MTM interventions, both telephonic and face-to-face;
- Number of comprehensive medication reviews;
- Number of drug therapy problems identified, such as potential drug-drug interactions, adverse events, or the simplification of a complex regimen with the same therapeutic benefit; and
- Number of drug therapy problems resolved, such as modifications to drug dose, form, or frequency or changes in drug regimen due to identification of potential adverse event or interaction.
- If specific disease states are targeted, the MCO shall include the following:
- Number of drug-related parameters improved, such as improved adherence in disease-specific medication regimen, modifications in drug therapy to reflect appropriate current treatment guidelines, or disease-related laboratory test monitoring;
- Percentage of the MCO's enrollee population with each targeted disease state that received MTM services; and
- An example of a positive outcome demonstrated by MTM interventions for each targeted disease state. Examples include improvement in blood pressure measurements, A1C levels, LDL levels, etc.

This information shall be submitted to LDH on a quarterly basis, by the 30th day of the month following the end of the reporting period.

Mosquito Repellent Coverage

The MCO shall cover mosquito repellant as a pharmacy benefit to decrease the risk of exposure to the Zika virus.

Coverage must be provided for enrollees who are:

- Pregnant; or
- Of childbearing age (women and men ages 14-44) who are trying to conceive.

One bottle of mosquito repellent every rolling 30 days will be allowed. A prescription will be required to cover one of the following products:

Product Name	Ounces	Bill As	UPC	"NDC"
Cutter Backwoods 25% Spray	6 oz.	170 g	71121962805	71121-0962-80
Cutter Skinsations 7% Spray	6 oz.	177 mL	16500540106	16500-0540-10
OFF! Family Care 15% Spray	2.5 oz.	71 g	46500018428	46500-0710-37
OFF! Deep Woods Dry 25% Spray	4 oz.	113 g	46500717642	46500-0717-64
OFF! Deep Woods 25% Spray	6 oz.	170 g	46500018428	46500-0018-42
OFF! Active 15% Spray	6 oz.	170 g	46500018107	46500-0018-10
Repel Sportsmen 25% Spray	6.5 oz.	184 g	11423941375	11423-0941-37
Repel Sportsmen Max 40% Spray	6.5 oz.	184 g	11423003387	11423-0003-38
Natrapel 20% Picaridin	5 oz.	177 mL	44224068781	44224-0068-78
Sawyer Insect Repellent 20% Picaridin	4 oz.	118 mL	50716005448	50716-0005-44

Opioid Prescription Policy

The MCO shall have an opioid prescription policy that includes the following:

- Acute Pain
  - 7-day quantity limit for opioid-naïve enrollees or Morphine Milligram Equivalent (MME) limit of 90 milligram per day, whichever is less. Opioid-naïve enrollees are enrollees with no opioid claims in the most current 90 days.
- Chronic Pain
  - Morphine Milligram Equivalent (MME) limit of 90 milligram per day for all opioid prescriptions.
- Exemptions that bypass opioid quantity limits shall include:

DIAGNOSIS DESCRIPTION	CODE
Cancer	C00.* – C96.*
Palliative Care	Z51.5
Burn of second or third degree of head, face and neck	T20.2* – T20.3*
Corrosion of second or third degree of head, face and neck	T20.6* – T20.7*
Burn of second or third degree of trunk	T21.2* – T21.3*
Corrosion of second or third degree of trunk	T21.6* – T21.7*
Burn of second or third degree of shoulder and upper limb, except wrist and hand	T22.2* – T22.3*
Corrosion of second or third degree of shoulder and upper limb, except wrist and hand	T22.6* – T22.7*
Burn of second or third degree of wrist and hand	T23.2* – T23.3*
Corrosion of second or third degree of wrist and hand	T23.6* – T23.7*
Burn of second or third degree of lower limb, except ankle and foot	T24.2* – T24.3*
Corrosion of second or third degree of lower limb, except ankle and foot	T24.6* – T24.7*
Burn of second or third degree of ankle and foot	T25.2* – T25.3*

Corrosion of second or third degree of ankle and foot	T25.6* – T25.7*
Hb-SS disease with crisis	D57.0
Hb-SS disease with crisis, unspecified	D57.00
Hb-SS disease with acute chest syndrome	D57.01
Hb-SS disease with splenic sequestration	D57.02
Sickle-cell/Hb-C disease with crisis	D57.21
Sickle-cell/Hb-C disease with acute chest syndrome	D57.211
Sickle-cell/Hb-C disease with splenic sequestration	D57.212
Sickle-cell/Hb-C disease with splenic sequestration	D57.219
Sickle-cell thalassemia with crisis	D57.41
Sickle-cell thalassemia with acute chest syndrome	D57.411
Sickle-cell thalassemia with splenic sequestration	D57.412
Sickle-cell thalassemia with crisis, unspecified	D57.419
Other sickle-cell disorders with crisis	D57.81
Other sickle-cell disorders with acute chest syndrome	D57.811
Other sickle-cell disorders with splenic sequestration	D57.812
Other sickle-cell disorders with crisis, unspecified	D57.819

Pharmacy Copayment

Copayment Threshold

The MCO must have a Point of Sale edit that will apply a per-enrollee maximum monthly copayment and turn off cost sharing when maximum copayments are met.

All copay exemptions shall be applied. The fiscal intermediary provides a monthly report to the MCOs with the per-enrollee maximum monthly copayment. This will eliminate all of the risk for enrollees to exceed the 5 percent aggregate family limit.

Exemptions for Preventive Medications

To be in compliance with the Affordable Care Act (ACA) requirements related to coverage of preventive medications, medications listed in the U.S. Preventive Services Task Force (USPSTF) A and B Recommendations should be reimbursable and exempt from pharmacy copayments. Corresponding age limits may be applied.

Prior Authorization

Refer to the Contract for prior authorization requirements.

Additionally, MCOs may not require prior authorization for drugs with FDA indication for emergency contraception.

340B Policy for Claim Level Indicators

The MCO is required to submit drug-related encounter data to LDH for the purposes of collecting federal Medicaid rebates. Louisiana Medicaid must prevent duplicate discounts against drug manufacturers when 340B covered

entities dispense drugs purchased through the 340B Discount Program. Federal Medicaid rebates are not allowed on 340B discount drug utilization.

340B is a federal program administered by the Health Resources and Services Administration (HRSA). HRSA's Office of Pharmacy Affairs (OPA) maintains a searchable database of all healthcare providers enrolled as 340B covered entities. Medicaid and Managed Care Medicaid claims billed by 340B covered entities that self-attest to HRSA that their Medicaid populations are carved into their 340B programs are removed from Federal Medicaid Rebate invoicing. This means the provider attests that their Medicaid claims are all 340B discount stock and are not eligible for Federal Rebate collection. Louisiana Medicaid requires a claim-level indicator be used by the billing provider in order to denote a drug claim's status as 340B. Due to the cost to charge methodology, outpatient hospital claims are excluded from the claim level indicator requirement.

MCOs should include the following requirements in contracts with 340B covered entities.

- Pharmacy 340B Drug Claims:
  - NCPDP: Bill value of "20" in the Submission Clarification Code field (420-DK).
  - NCPDP: Bill value of "08" in the Basis of Cost Determination field (423-DN).
- Outpatient/Professional Services 340B Drug Claims:
  - CMS 1450/UB04: Enter UD Modifier immediately following drug HCPCS/CPT code in field 44. For example, HCPCS J1111 billed as J1111UD.
  - CMS 1500: Enter HCPCS code in field 24C followed by the UD Modifier. 837I: Loop 2400 SV2 can send up to four modifiers SV202-3, SV202-4, SV202-5, and SV202-6.
  - 837I: Loop 2400 SV2 can send up to four modifiers SV202-3, SV202-4, SV202-5, and SV202-6
  - 837P: Loop 2400 SV1 can send up to four modifiers in SV101-3, SV101-4, SV101-5, and SV101-6.

The MCO shall deny claims at Point of Sale (POS) from 340B carved-in pharmacies that have missing or invalid claim level indicators. The MCO shall require submission of the UD modifier on 340B outpatient/professional services drug claims. Encounters shall follow requirements in the **Batch Pharmacy Encounters Companion Guide**.

Hepatitis C Virus Direct-Acting Antiviral (DAA) Agents

The MCO shall deny claims at POS for hepatitis C direct-acting antiviral agents from 340B pharmacies carved-in to Medicaid. Claims for hepatitis C direct-acting antiviral agents from 340B carve-out pharmacies are not subject to this limitation and shall process as usual.

Vaccines for Adults

The MCO shall allow 340B pharmacies carved-in to Medicaid to bill vaccines and administration for adults (19 years and older) at POS as a pharmacy benefit. Claim level indicators should not be required on claims for vaccines. Vaccines are not 340B or rebate eligible.

Inpatient 340B Drug Claims

Drugs are not billed separately from the per-diem inpatient rate. Per HRSA guidelines, 340B stock must not be dispensed in an inpatient setting.

340B Exclusion

Only providers registered as 340B covered entities and listed on the HRSA Medicaid Exclusion File may bill drug stock purchased through 340B with these indicators. The indicator is meant to denote that the specific drug billed on the claim was obtained through the 340B discount program by the billing provider.

These modifiers should not be used by providers that are not registered 340B covered entities, or by covered entities that are not listed on the Exclusion File because they have attested that they do not use 340B drug stock for their Medicaid beneficiaries.

340B contract pharmacies are not permitted to bill 340B stock to Medicaid FFS or MCOs in Louisiana.

The MCO should deny claims at POS if the 340B indicators are on the claim, but the pharmacy is not listed in the Medicaid Exclusion File. The pharmacy should be directed to fill the claim with regular pharmacy stock with the denial.

Claims with these modifiers will be excluded from federal Medicaid rebate invoicing only when billed by 340B covered entities listed on the Medicaid Exclusion file as using their 340B drug stock for Medicaid beneficiaries.

PORTABLE X-RAY SERVICES

The MCO shall cover portable x-rays for enrollees who are unable to travel to a physician's office or outpatient hospital's radiology facility.

Covered Services

The MCO shall cover specific diagnostic radiology services for an eligible enrollee to be provided in the enrollee's place of residence by an enrolled portable x-ray provider.

Covered radiographs shall be limited to:

- Skeletal films of an enrollee's limbs, pelvis, vertebral column or skull;
- Chest films which do not involve the use of contrast media; and
- Abdominal films which do not involve the use of contrast media.

NOTE: The MCO shall not reimburse for technical components of these services as a separate part of the service. Providers billing for these services must bill a full component only.

The MCO shall cover transportation of portable x-ray equipment only when the equipment used is actually transported to the location where x-ray services are provided.

The MCO shall reimburse only a single transportation payment per trip to a facility or location for a single date of service.

The MCO shall require the physician's order to clearly state the following:

- Suspected diagnosis or the reason the x-ray is required;
- Area of the body to be exposed;
- Number of radiographs ordered; and

- ❖ Precise views needed.

The enrollee's place of residence is defined as:

- ❖ The enrollee's private home;
- ❖ A nursing facility; or
- ❖ An intermediate care facility for the developmentally disabled.

Enrollee Qualifications

Enrollees must be home bound. Enrollees are considered to be homebound when a medical condition causes them to be unable to leave their place of residence without the use of special transportation or the assistance of another person. The place of residence may be the enrollee's own home, a nursing home or an intermediate care facility for a person with a developmental disability.

Provider Requirements

The MCO shall require providers to comply with the following regarding portable x-rays:

- ❖ Comply with all Medicare guidelines for portable x-ray providers;
- ❖ Maintain certification to practice radiology in the state of Louisiana;
- ❖ Enroll with Louisiana Medicaid as a portable x-ray provider; and
- ❖ Exist independently of any hospital, clinic, or physician's office.

The MCO shall ensure that portable x-ray services are provided under the general supervision of a licensed physician who is qualified by advanced training and experienced in the use of diagnostic x-rays. The supervising physician is responsible for the ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform the tests, and the qualifications of non-physician personnel that use the equipment. Any non-physician personnel utilized by the portable x-ray provider to perform tests must demonstrate the basic qualifications and possess appropriate training and proficiency as evidence by licensure or certification.

PROFESSIONAL SERVICES

Abortion

Induced Abortion

The use of public funds to provide induced abortion services must meet applicable state and federal laws, including the requirements of the Hyde Amendment (currently found in La. R.S. 40.1061.6 and the Consolidated Appropriations Act, 2014, Public Law 113-76, Division H, Title V, §506 and §507).

MCO coverage of induced abortion is restricted to those that meet the following criteria:

- ❖ A physician has found, and so certifies, that on the basis of his/her professional judgment, the life of the pregnant woman would be endangered if the fetus was carried to term.

- The certification statement, which must contain the name and address of the enrollee, must be attached to the claim form. The diagnosis or medical condition which makes the pregnancy life endangering must be specified on the claim.

OR

- In the case of terminating a pregnancy due to rape or incest the following requirements must be met:
    - The enrollee shall report the act of rape or incest to a law enforcement official unless the treating physician certifies in writing that in the physician's professional opinion, the victim was too physically or psychologically incapacitated to report the rape or incest.
    - The report of the act of rape or incest to a law enforcement official or the treating physician's statement that the victim was too physically or psychologically incapacitated to report the rape or incest must be submitted to the MCO along with the treating physician's claim for reimbursement for performing an abortion.
    - The enrollee shall certify that the pregnancy is the result of rape or incest, and this certification shall be witnessed by the treating physician.
    - The "Office of Public Health Certification of Informed Consent-Abortion" form shall be witnessed by the treating physician.

In order for Medicaid reimbursement to be made for an induced abortion, providers must attach a copy of the "Office of Public Health Certification of Informed Consent-Abortion" form to their claim form. The form is to be obtained from the Louisiana Office of Public Health via a request form [link] or by calling (504) 568-5330.

Claims associated with an induced abortion, including those of the attending physician, hospital, assistant surgeon, and anesthesiologist must be accompanied by a copy of the attending physician's certifications, as applicable. Therefore, the MCO shall require providers to submit only hard-copy claims for payment consideration.

All claim forms and attachments shall be retained by the MCO. The MCO shall forward a copy of the claim and its accompanying documentation to LDH if requested.

Threatened, Incomplete or Missed Abortion

As a condition of reimbursement, claims for treatments related to a threatened, incomplete, or missed abortion must include the enrollee history and complete documentation of treatment.

Supportive documentation that will substantiate reimbursement may include one or more of the following, but is not limited to:

- Sonogram report showing no fetal heart tones;
- History indicating passage of fetus at home, en route, or in the emergency room;
- Pathology report showing degenerating products of conception; or
- Pelvic exam report describing stage of cervical dilation.

Advanced Practice Registered Nurses: Clinical Nurse Specialists, Certified Nurse Practitioners, and Certified Nurse Midwives

An advanced practice registered nurse (APRN) must hold a current, unencumbered and valid license from the Louisiana Board of Nursing to participate in Louisiana Medicaid. A nurse licensed as an APRN includes a:

- Clinical Nurse Specialist (CNS)
- Certified Nurse Practitioner (CNP)
- Certified Nurse Midwife (CNM)

Advanced practice registered nurses shall comply with their scope of practice as authorized by Louisiana state law and regulations.

CNS/CNP/CNMs must obtain an individual Medicaid provider number and, when the rendering provider, must bill under this provider number for services rendered.

Physicians who employ or contract with CNS/CNP/CNMs must obtain a group provider number and link the individual CNS/CNP/CNM provider number to the group number.

CNS/CNP/CNMs employed or under contract to a group or facility may not bill individually for the same services for which reimbursement is made to the group or facility.

Reimbursement

Unless otherwise excluded by the Medicaid Program, coverage of services will be determined by individual licensure, scope of practice, and terms of the physician collaborative agreement. Collaborative agreements must be available for review upon request by authorized representatives of the Medicaid program and contracted MCOs.

Immunizations, physician-administered drugs, long-acting reversible contraceptives, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) medical, vision, and hearing screens are reimbursed at a minimum of 100% of the physician fee on file. All other payable procedures are reimbursed at a minimum of 80% of the physician fee on file.

After Hours Care on Evenings, Weekends, and Holidays

This policy is intended to facilitate enrollee access to services during non-typical hours primarily to reduce the inappropriate use of the hospital emergency department. The reimbursement for the evening, weekend, and holiday codes is intended to assist with coverage of the additional administrative costs associated with staffing during these times.

The *Current Procedural Terminology* (CPT) evening, weekend, and holiday codes are reimbursed in addition to the reimbursement for most outpatient evaluation and management (E&M) services when the services are rendered in settings other than hospital emergency departments during the hours of:

- Monday through Friday between 5 p.m. and 8 a.m. (when outside of regular office hours),
- Weekends (12 a.m. Saturday through midnight on Sunday), or

- State/Governor proclaimed legal holidays (12 a.m. through midnight).

Only one of the evening, weekend, and holiday codes may be submitted by a billing provider per day per enrollee. Providers should select the evening, weekend, and holiday procedure code that most accurately reflects the situation on a particular date. These codes are never reported alone, but rather in addition to another code or codes describing the service related to that enrollee's visit or encounter. The following examples illustrate the appropriate use of evening, weekend, and holiday procedure codes based on the situation described.

- If the existing office hours are Monday through Friday from 8 a.m. to 5 p.m., and the physician treats the enrollee in the office at 7 p.m., then the provider may report the appropriate basic service (E&M visit code) and evening, weekend, and holiday code.
- If the existing office hours are Monday through Friday from 8:30 a.m. to 6:30 p.m., and the physician treats the enrollee in the office at 6 p.m., then the provider may not report the evening, weekend, and holiday code.
- If an enrollee is seen in the office on Saturday during existing office hours, then the provider may report the appropriate basic service (E&M visit code) and evening, weekend, and holiday code.

Documentation in the medical record relative to this reimbursement must include the time the services were rendered.

Reimbursement

The reimbursement for evening, weekend and holiday services is based on the following current CPT codes or their successors.

- 99050 (Services…at times other than regularly scheduled office hours…) or
- 99051 (Services …at regularly scheduled evening, weekend, or holiday hours…).

When used, these procedure codes must be submitted with the code(s) for the associated evaluation and management services on that date.

Allergy Testing and Allergen Immunotherapy

Allergy Testing

The MCO shall only cover allergy testing for children and adults who have symptoms that suggest they have an allergic disease. Allergy symptoms may include, but are not limited to:

- Respiratory symptoms: itchy eyes, nose, or throat, nasal congestion, runny nose, watery eyes, chest congestion or wheezing,
- Skin symptoms: hives, generalized itchiness or atopic dermatitis, and
- Other symptoms: anaphylaxis (severe life-threatening allergic reactions) or abdominal symptoms (cramping, diarrhea) that consistently follow particular foods or stinging insect reactions (other than large local swelling at the sting site).

Allergen Immunotherapy

The MCO's policy for allergen immunotherapy shall include the following:

- Allergen immunotherapy is only recommended for allergic asthma, allergic rhinitis and conjunctivitis, and stinging insect allergy. Immunotherapy for food allergies is not recommended. Decisions to initiate immunotherapy should be based on severity of allergy symptoms, other possible treatment options, and cost of treatment options.
- Five years of age is the youngest recommended age to begin immunotherapy. There is no upper age limit for receiving immunotherapy. However, before initiating immunotherapy in an older person, consideration must be given to other common medical conditions that could make immunotherapy more risky.

Anesthesia

Surgical Anesthesia

The MCO shall cover surgical anesthesia services when provided by an anesthesiologist or certified registered nurse anesthetist (CRNA).

Coverage for surgical anesthesia procedures must be based on formulas utilizing base units, time units (1 unit = 15 min) and a conversion factor as identified in the Anesthesia Fee Schedules. Minutes must be reported on anesthesia claims.

Administration of anesthesia by the provider performing the surgical procedure for a non-obstetrical surgery shall not be covered.

The MCO shall require the following modifiers to be used to submit surgical anesthesia services:

Modifier	Servicing Provider	Surgical Anesthesia Service
AA	Anesthesiologist	Anesthesia services performed personally by the anesthesiologist
QY	Anesthesiologist	Medical direction* of one CRNA
QK	Anesthesiologist	Medical direction* of two, three, or four concurrent anesthesia procedures involving qualified individuals
QX	CRNA	CRNA service with direction* by an anesthesiologist
QZ	CRNA	CRNA service without medical direction* by an anesthesiologist

*See *Medical Direction* for further explanation.

The following are acceptable uses of modifiers:

- Modifiers which can stand alone: AA and QZ;
- Modifiers which need a partner: QK, QX and QY; and
- Valid combinations: QK and QX, or QY and QX.

Medical Direction

Medical direction is defined as:

- Performing a pre-anesthetic examination and evaluation;

- ❖ Prescribing the anesthesia plan;
- ❖ Participating personally in the most demanding procedures in the anesthesia plan, including induction and emergence;
- ❖ Ensuring that any procedures in the anesthesia plan that he/she does not perform are rendered by a qualified individual;
- ❖ Monitoring the course of anesthesia administration at frequent intervals;
- ❖ Remaining physically present and available for immediate diagnosis and treatment of emergencies; and
- ❖ Providing the indicated post-anesthesia care.

The MCO shall reimburse only anesthesiologists for medical direction.

Maternity-Related Anesthesia

The MCO shall cover maternity-related anesthesia services when provided by anesthesiologists, CRNAs, or the delivering physician.

The MCO shall require the delivering physician to use CPT codes in the Surgery Maternity Care and Delivery section of the CPT manual to bill for maternity-related anesthesia services.

Reimbursement for these services shall be a flat fee, except for general anesthesia for vaginal delivery.

The MCO shall require the following modifiers to be used when providing maternity-related anesthesia services:

Modifier	Servicing Provider	Service Performed
AA	Anesthesiologist	Anesthesia services performed personally by the anesthesiologist
QY	Anesthesiologist	Medical direction* of one CRNA
QK	Anesthesiologist	Medical direction* of two, three, or four concurrent anesthesia procedures
QX	CRNA	CRNA service with medical direction* by an anesthesiologist
QZ	CRNA	CRNA service without medical direction* by an anesthesiologist
47	Delivering Physician	Anesthesia provided by delivering physician
52	Delivering Physician or Anesthesiologist	Reduced services
QS	Anesthesiologist or CRNA	Monitored anesthesia care service The QS modifier is a secondary modifier only, and must be paired with the appropriate anesthesia provider modifier (either the anesthesiologist or the CRNA). The QS modifier indicates that the provider did not introduce the epidural for anesthesia, but did monitor the enrollee after catheter placement.

*See Medical Direction section for further explanation.

Add-on Codes for Maternity-Related Anesthesia

When an add-on code is used to fully define a maternity-related anesthesia service, the MCO shall require the date of delivery be the date of service for both the primary and add-on code.

An add-on code in and of itself is not a full service and typically cannot be reimbursed separately to different providers. The exception is when more than one provider performs services over the duration of labor and delivery.

A group practice frequently includes anesthesiologists and/or CRNA providers. One member may provide the pre-anesthesia examination/evaluation, and another may fulfill other criteria. The MCO shall require that the medical record indicate the services provided and identify the provider who rendered the service.

Maternity-Related Anesthesia

Reimbursement for maternity-related procedures, other than general anesthesia for vaginal delivery, shall be a flat fee.

The MCO shall ensure that minutes be reported on all maternity-related anesthesia claims.

The MCO shall require providers to follow the chart below when billing for maternity-related anesthesia.

Type of Anesthesia	CPT Code	Modifier	Reimbursement	Service
Vaginal Delivery General Anesthesia	01960	Valid Modifier	Formula	Anesthesiologist performs complete service, or direction of the CRNA
				CRNA performs complete service with or without direction by Anesthesiologist
Epidural for Vaginal Delivery	01967	AA, QY or QK for MD; QX or QZ for CRNA	Flat Fee	See modifier list for maternity-related services
Cesarean Delivery only (epidural or general)	01961	AA, QY or QK for MD; QX or QZ for CRNA	Flat Fee	See modifier list for maternity-related services
Cesarean Delivery after Epidural, for planned vaginal delivery	01967 + 01968	AA, QY or QK for MD; QX or QZ for CRNA	Flat Fee plus add-on	See modifier list for maternity-related services
Cesarean Hysterectomy after Epidural and Cesarean Delivery	01967 + 01969	AA, QY or QK for MD; QX or QZ for CRNA	Flat Fee plus add-on	See modifier list for maternity-related services
Epidural – Vaginal Delivery	59409 59612	47	Fee for delivery plus additional reimbursement for anesthesia	Delivering physician provides the entire service for vaginal delivery
Epidural – Vaginal Delivery	59409 59612	47 and 52	Fee for delivery plus additional reimbursement for anesthesia	Introduction only by the delivering physician
Epidural – Vaginal Delivery	01967	AA and 52	Flat Fee	Introduction only by anesthesiologist
Epidural – Vaginal Delivery	01967	AA and QS for MD; QZ and QS or QX and QS for CRNA	Flat Fee	Monitoring by anesthesiologist or CRNA
Cesarean Delivery	59514 59620	47 and 52	Fee for delivery plus additional reimbursement for anesthesia	Introduction only by the delivering physician

Cesarean Delivery – after Epidural	01961	AA and 52	Flat Fee	Introduction only by the anesthesiologist
Cesarean Delivery- following Epidural for planned vaginal delivery	01967 + 01968	AA and 52	Flat Fee plus add-on	Introduction only by the anesthesiologist
Cesarean Delivery – after Epidural	01961	AA and QS for MD; QZ and QS or QX and QS for CRNA	Flat Fee	Monitoring by the anesthesiologist or CRNA
Cesarean Delivery- following Epidural for planned vaginal delivery	01967 + 01968	AA and QS for MD; QZ and QS or QX and QS for CRNA	Flat Fee plus add-on	Monitoring by the anesthesiologist or CRNA

Anesthesia for Tubal Ligation or Hysterectomy

Anesthesia reimbursement for tubal ligations and hysterectomies shall be formula-based, with the exception of anesthesia for cesarean hysterectomy (CPT code 01969).

The reimbursement for CPT codes 01967 and 01969, when billed together, shall be a flat fee. CPT code 01968 is implied in CPT code 01969 and should not be placed on the claim form if a cesarean hysterectomy was performed after cesarean section delivery.

Pediatric Moderate (Conscious) Sedation

Moderate sedation does not include minimal sedation (anxiolysis), deep sedation or monitored anesthesia care.

Moderate sedation coverage shall be restricted to enrollees from birth to age 13. Exceptions to the age restriction shall be made for children who have severe developmental disabilities; however, no claims shall be considered for enrollees 21 years of age or older.

Moderate sedation includes the following services (which are not to be reported/billed separately):

- Assessment of the enrollee (not included in intra-service time);
- Establishment of intravenous (IV) access and fluids to maintain patency, when performed;
- Administration of agents;
- Maintenance of sedation;
- Monitoring of oxygen saturation, heart rate and blood pressure; and
- Recovery (not included in intra-service time).

Intra-service time starts with the administration of the sedation agents, requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation.

The MCO shall reimburse a second physician other than the healthcare professional performing the diagnostic or therapeutic when the second physician provides moderate sedation in a facility setting (e.g., hospital, outpatient hospital, ambulatory surgical center, skilled nursing facility). However, moderate sedation services performed by a second physician in a non-facility setting (e.g., physician office, freestanding imaging center) should not be reported.

Provider Claims Filing

The MCO's policy for filing of claims related to anesthesia services shall include the following.

Anesthesia Time

Anesthesia time begins when the provider begins to prepare the enrollee for induction and ends with termination of the administration of anesthesia. Time spent in pre- and postoperative care may not be included in the total anesthesia time.

Multiple Surgical Procedures

Anesthesia for multiple surgical (non-OB) procedures in the same anesthesia session must be billed on one claim line using the most appropriate anesthesia code with the total anesthesia time spent reported in item 24G on the claim form. The only secondary procedures that are not to be billed in this manner are tubal ligations and hysterectomies.

Vaginal Delivery – Complete Anesthesia Service by Delivering Physician

The delivering physician should submit a claim for the delivery and anesthesia on a single claim line with modifier.

Assistant Surgeon/Assistant at Surgery

The MCO shall reimburse for **only one** assistant at surgery. The assistant to the surgeon should be a qualified physician. However, in those situations when a physician does not serve as the assistant, qualified, enrolled, advanced practice registered nurses and physician assistants may function in the role of an assistant at surgery and submit claims for their services under their Medicaid provider number.

Physicians serving as the assistant are to use the modifier "80" on the procedure code(s) representing their services.

Advanced practice registered nurses, certified nurse midwives, and physician assistants are to use the modifier "AS" when reporting their services as the only assistant at surgery.

Bariatric Surgery

Bariatric surgery consists of open or laparoscopic procedures that revise the gastrointestinal anatomy to restrict the size of the stomach, reduce absorption of nutrients, or both.

Eligibility Criteria

The MCO shall cover bariatric surgery when medically necessary, as determined by meeting all of the following criteria:

- The enrollee has received a preoperative evaluation within the previous 12 months that is conducted by a multidisciplinary team including, at a minimum, a physician, nutritionist or dietician, and a licensed

qualified mental health professional. For enrollees under the age of 18, the multidisciplinary team must have pediatric expertise. For all enrollees, the preoperative evaluation must document all of the following:

- A determination that previous attempt(s) at weight loss have been unsuccessful and that future attempts, other than bariatric surgery, are not likely to be successful; and
- A determination that the enrollee is capable of adhering to the post-surgery diet and follow-up care; and
- For individuals capable of becoming pregnant, counseling to avoid pregnancy preoperatively and for at least 12 months postoperatively and until weight has stabilized.

❖ Enrollees age 18 and older must have:

- A body mass index equal to or greater than 40 kg/m^2, or more than 100 pounds overweight; or
- A body mass index of greater or equal to 35 kg/m^2 with one or more comorbidities related to obesity:
  - Type 2 diabetes mellitus,
  - Cardiovascular disease (e.g., stroke, myocardial infarction, poorly controlled hypertension (systemic blood pressure greater than 140 mm Hg or diastolic blood pressure 90 mm Hg or greater, despite pharmacotherapy),
  - History of coronary artery disease with a surgical intervention such as coronary artery Bypass or percutaneous transluminal coronary angioplasty,
  - History of cardiomyopathy,
  - Obstructive sleep apnea confirmed on polysomnography with an AHI or RDI of ≥ 30, or
  - Any other comorbidity related to obesity that is determined by the preoperative evaluation to be improved by weight loss; or
- A body mass index of 30 to 34.9 kg/m^2 with type 2 diabetes mellitus if hyperglycemia is inadequately controlled despite optimal medical control by oral or injectable medications.

❖ Enrollees age 13 through 17 years old must have:

- A body mass index equal to or greater than 40 kg/m^2 or 140% of the 95th percentile for age and sex, whichever is lower; or
- A body mass index of 35 to 39.9 kg/m^2 or 120% of the 95th percentile for age and sex, whichever is lower, with one or more comorbidities related to obesity:
  - Obstructive sleep apnea confirmed on polysomnography with an AHI > 5,
  - Type 2 diabetes mellitus,
  - Idiopathic intracranial hypertension
  - Nonalcoholic steatohepatitis,
  - Blount's disease,
  - Slipped capital femoral epiphysis,
  - Gastroesophageal reflux disease,
  - Hypertension, or
  - Any other comorbidity related to obesity that is determined by the preoperative evaluation to be improved by weight loss.

❖ The MCO shall review the medical necessity of requests for bariatric surgery for enrollees under the age of 13 on a case-by-case basis.

Panniculectomy Subsequent to Bariatric Surgery

The MCO shall cover panniculectomy after bariatric surgery when medically necessary, as determined by the following criteria:

- The enrollee had bariatric surgery at least 18 months prior and the enrollee's weight has been stable for at least 6 months; and
- The pannus is at or below the level of the pubic symphysis; and
- The pannus causes significant consequences, as indicated by at least one of the following:
  - Cellulitis, other infections, skin ulcerations, or persistent dermatitis that has failed to respond to at least 3 months of non-surgical treatment; or
  - Functional impairment such as interference with ambulation.

Breast Surgery

Mastectomy

The MCO shall cover mastectomy and breast conserving surgery when medically necessary.

Risk-reducing mastectomy to prevent cancer shall be considered medically necessary for enrollees that meet all of the following criteria:

- A high risk of breast cancer, as defined by one or more of the following:
  - Positive genetic mutation that is known or likely to confer a high risk of breast cancer (e.g., *BRCA1* and *BRCA2*) where risk-reducing mastectomy is recommended by National Comprehensive Cancer Network guidelines; or
  - Significant family history, as defined by meeting the family history criteria listed under "Breast and Ovarian Cancer" within the "Genetic Testing" policy; or
  - Prior thoracic radiation therapy at an age less than 30 years old; and
- A life expectancy greater than or equal to 10 years.

Breast Reconstruction

The MCO shall cover reconstructive breast surgery after a therapeutic intervention (e.g., mastectomy) or trauma resulting in significant loss of breast tissue.

The following services shall be considered medically necessary:

- Reconstruction of the affected breast;
- Reconstruction of the contralateral breast to produce a symmetrical appearance;
- Prostheses (implanted, external, or both); and
- Treatment of complications of the reconstruction.

All prosthetic implants must be FDA approved and used in compliance with all FDA requirements at the time of the surgery.

Reduction Mammaplasty and Removal of Breast Implants

The MCO shall cover reduction mammaplasty and removal of breast implants for the purpose of breast reconstruction under the above breast reconstruction policy.

Reduction mammaplasty for purposes other than reconstruction shall be considered medically necessary when all of the following criteria are met:

- Pubertal breast development is complete;
- A diagnosis of macromastia with at least two of the following symptoms for at least a 12-week duration:
  - Chronic breast pain
  - Headache
  - Neck, shoulder, or back pain
  - Shoulder grooving from bra straps
  - Upper extremity paresthesia due to brachial plexus compression syndrome, secondary to the weight of the breasts being transferred to the shoulder strap area
  - Thoracic kyphosis
  - Persistent skin condition such as intertrigo in the inframammary fold that is unresponsive to medical management
  - Congenital breast deformity;
- There is a reasonable likelihood that the symptoms are primarily due to macromastia; and
- The amount of breast tissue to be removed is reasonably expected to alleviate the symptoms.

Removal of breast implants for purposes other than reconstruction shall be considered medically necessary for the following indications:

- Visible capsular contracture causing pain (Baker Grade IV)
- Diagnosed or suspected implant rupture
- Local or systemic infection
- Siliconoma or granuloma
- Implant extrusion
- Interference with the diagnosis or treatment of breast cancer
- Breast implant-associated anaplastic large cell lymphoma

If an indication for medically necessary removal of breast implants is present unilaterally, removal of the contralateral breast implant shall also be considered medically necessary when performed during the same operative session.

When the procedure is not reconstructive and is performed solely for the purpose of altering the appearance of the breast, reduction mammaplasty and removal of breast implants shall be considered cosmetic and not medically necessary.

Cardiovascular Services

Invasive Coronary Angiography and Percutaneous Coronary Intervention

The MCO shall cover elective invasive coronary angiography (ICA) and percutaneous coronary intervention (PCI) as treatment for cardiovascular conditions under specific circumstances.

This policy only applies to enrollees age 18 and older and does not apply to the following enrollees:

- Enrollees under the age of 18;
- Pregnant enrollees;
- Cardiac transplant enrollees;
- Solid organ transplant candidates; and
- Survivors of sudden cardiac arrest.

Eligibility Criteria

Elective Invasive Coronary Angiography (ICA)

The MCO shall cover elective ICA and consider it medically necessary in enrollees with one or more of the following:

- Congenital heart disease that cannot be characterized by non-invasive modalities such as cardiac ultrasound, CT, or MRI;
- Heart failure with reduced ejection fraction for the purposes of diagnosing ischemic cardiomyopathy;
- Hypertrophic cardiomyopathy prior to septal ablation or myomectomy;
- Severe valvular disease or valvular disease with plans for surgery or percutaneous valve replacement;
- Type 1 myocardial infarction within the past three months defined by detection of a rise and/or fall of cardiac troponin values with at least one value above the 99th percentile upper reference limit and with at least one of the following:
    - Symptoms of acute myocardial ischemia;
    - New ischemic electrocardiogram (ECG) changes;
    - Development of pathological Q waves;
    - Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality in a pattern consistent with an ischemic etiology; and
    - Identification of a coronary thrombus;
- History of ventricular tachycardia requiring therapy for termination or sustained ventricular tachycardia not due to a transient reversible cause, within the past year;
- History of ventricular fibrillation;
- Return of angina within nine months of prior PCI;
- Enrollees without chronic kidney disease who have Canadian Cardiovascular Society class I-IV classification of angina with intolerance of or failure to respond to at least two target dose anti-anginal medications

(beta blocker, dihydropyridine or non-dihydropyridine calcium channel blocker, nitrates, and/or ranolazine); or

- ❖ High risk imaging findings, defined as one or more of the below:
    - o Severe resting left ventricular dysfunction (LVEF ≤35%) not readily explained by noncoronary causes;
    - o Resting perfusion abnormalities ≥10% of the myocardium in enrollees without prior history or evidence of myocardial infarction;
    - o Stress electrocardiogram findings including ≥2 mm of ST-segment depression at low workload or persisting into recovery, exercise-induced ST-segment elevation, or exercise-induced ventricular tachycardia/ventricular fibrillation;
    - o Severe stress-induced left ventricular dysfunction (peak exercise LVEF <45% or drop in LVEF with stress ≥10%);
    - o Stress-induced perfusion abnormalities affecting ≥10% myocardium or stress segmental scores indicating multiple vascular territories with abnormalities;
    - o Stress-induced left ventricular dilation;
    - o Inducible wall motion abnormality (involving >2 segments or 2 coronary beds);
    - o Wall motion abnormality developing at low dose of dobutamine (≥10 mg/kg/min) or at a low heart rate (<120 beats/min); or
    - o Left main stenosis (≥50% stenosis) on coronary computed tomography angiography.

Elective Percutaneous Coronary Intervention (PCI)

The MCO shall cover elective PCI for angina with stable coronary artery disease and consider it medically necessary in:

- ❖ Enrollees without chronic kidney disease who have Canadian Cardiovascular Society class I-IV classification of angina with intolerance of or failure to respond to at least two target dose anti-anginal medications (beta blocker, dihydropyridine or non-dihydropyridine calcium channel blocker, nitrates, and/or ranolazine).

Elective PCI for other cardiac conditions is considered medically necessary in enrollees with one or more of the following:

- ❖ Heart failure with reduced ejection fraction for the purposes of treating ischemic cardiomyopathy;
- ❖ Left main stenosis ≥50% as determined on prior cardiac catheterization or coronary computed tomography angiography, if the enrollee has documentation indicating they were declined for a coronary artery bypass graft surgery; and
- ❖ Type 1 myocardial infarction within the past three months as defined by detection of a rise and/or fall of cardiac troponin values with at least one value above the 99th percentile upper reference limit and with at least one of the following:
    - o Symptoms of acute myocardial ischemia;
    - o New ischemic electrocardiogram changes;
    - o Development of pathological Q waves;
    - o Imaging evidence of new loss of viable myocardium, or new regional wall motion abnormality in a pattern consistent with an ischemic etiology; and
    - o Identification of a coronary thrombus.

Elective PCI for non-acute, stable coronary artery disease is not considered medically necessary in all other enrollee populations, including if the enrollee is unwilling to adhere with recommended medical therapy, or if the enrollee is unlikely to benefit from the proposed procedure (e.g., life expectancy less than six months due to a terminal illness).

Endovascular Revascularization for Peripheral Artery Disease

The MCO shall cover endovascular revascularization procedures (stents, angioplasty, and atherectomy) for the lower extremity and consider them medically necessary for the following conditions:

- Acute limb ischemia;
- Chronic limb-threatening ischemia, defined as the presence of any of the following:
  - Ischemic pain at rest;
  - Gangrene; or
  - Lower limb ulceration greater than two weeks duration.

The MCO shall also cover endovascular revascularization procedures and consider them medically necessary in enrollees with peripheral artery disease who have symptoms of intermittent claudication and meet all of the following criteria:

- Significant peripheral artery disease of the lower extremity as indicated by at least one of the following:
  - Moderate to severe ischemic peripheral artery disease with ankle-brachial index (ABI) ≤0.69; or
  - Stenosis in the aortoiliac artery, femoropopliteal artery, or both arteries, with a severity of stenosis ≥70% by imaging studies; and
- Claudication symptoms that impair the ability to work or perform activities of daily living; and
- No improvement of symptoms despite all of the following treatments:
  - Documented participation in a medically supervised or directed exercise program for at least 12 weeks. Individuals fully unable to perform exercise therapy may qualify for revascularization only if the procedure is expected to provide long-term functional benefits despite the limitations that precluded exercise therapy; and
  - At least six months of optimal pharmacologic therapy including all of the below agents, unless contraindicated or discontinued due to adverse effects:
    - Antiplatelet therapy with aspirin, clopidogrel, or both
    - Statin therapy
    - Cilostazol
    - Antihypertensives to a goal systolic blood pressure ≤140 mmHg and diastolic blood pressure ≤90 mmHg; and
  - At least one documented attempt at smoking cessation, if applicable, consisting of pharmacotherapy, unless contraindicated, and behavioral counseling, or referral to a smoking cessation program that offers both pharmacotherapy and counseling.

Exclusions

The MCO shall not consider endovascular revascularization procedures for the lower extremity not medically necessary in the following circumstances:

- ❖ Claudication due to isolated infrapopliteal artery disease (anterior tibial, posterior tibial or peroneal) including enrollees with coronary artery disease, diabetes mellitus, or both;
- ❖ To prevent the progression of claudication to chronic limb-threatening ischemia in an enrollee who does not otherwise meet medical necessity criteria;
- ❖ Enrollee is asymptomatic; or
- ❖ Treatment of a nonviable limb.

Peripheral Arterial Disease Rehabilitation for Symptomatic Peripheral Arterial Disease

Peripheral arterial disease rehabilitation, also known as supervised exercise therapy, involves the use of intermittent exercise training for the purpose of reducing intermittent claudication symptoms.

The MCO shall cover and consider medically necessary up to 36 sessions of peripheral arterial disease rehabilitation annually. Delivery of these sessions three times per week over a 12-week period is recommended, but not required. The MCO shall direct providers to adhere to CPT guidance on the time per session, exercise activities permitted, and the qualifications of the supervising provider.

Chiropractic Services

The MCO shall cover chiropractic manipulative treatment for enrollees under 21 years of age when medically necessary and upon referral from an EPSDT medical screening primary care provider.

Cochlear Implant

The MCO shall cover unilateral or bilateral cochlear implants when deemed medically necessary for the treatment of severe-to-profound, bilateral sensorineural hearing loss in enrollees under 21 years of age. The MCO shall direct providers that any implant must be used in accordance with Food and Drug Administration (FDA) guidelines.

Eligibility Criteria

The MCO shall require a multidisciplinary implant team to collaborate on determining eligibility and providing care that includes, at minimum: a fellowship-trained pediatric otolaryngologist or fellowship-trained otologist, an audiologist, and a speech-language pathologist.

An audiological evaluation must find:

- ❖ Severe-to-profound hearing loss determined through the use of an age-appropriate combination of behavioral and physiological measures; and
- ❖ Limited or no functional benefit achieved after a sufficient trial of hearing aid amplification.

A medical evaluation must include:

- ❖ Medical history;

- Physical examination verifying the candidate has intact tympanic membrane(s), is free of active ear disease, and has no contraindication for surgery under general anesthesia;
- Verification of receipt of all recommended immunizations;
- Verification of accessible cochlear anatomy that is suitable to implantation, as confirmed by imaging studies (computed tomography (CT) and/or magnetic resonance imagery (MRI)), when necessary; and
- Verification of auditory nerve integrity, as confirmed by electrical promontory stimulation, when necessary.

For bilateral cochlear implants, an audiologic and medical evaluation must determine that a unilateral cochlear implant plus hearing aid in the contralateral ear will not result in binaural benefit for the enrollee.

Non-audiological evaluations must include:

- Speech and language evaluation to determine enrollee's level of communicative ability; and
- Psychological and/or social work evaluation, as needed.

Pre-operative counseling must be provided to the enrollee, if age appropriate, and the enrollee's caregiver and must provide:

- Information on implant components and function; risks, limitations, and potential benefits of implantation; the surgical procedure; and postoperative follow-up schedule;
- Appropriate post-implant expectations, including being prepared and willing to participate in pre- and post- implant assessment and rehabilitation programs; and
- Information about alternative communication methods to cochlear implants.

Preoperative Evaluation

If prior authorized, the MCO shall reimburse for preoperative evaluation services (i.e., evaluation of speech, language, voice, communication, auditory processing, and/or audiologic/aural rehabilitation) even when the enrollee may not subsequently receive an implant.

Implants, Equipment, Repairs, and Replacements

At the time of surgery, the MCO shall make reimbursement to the hospital for both the implant and the per diem. Refer to the *Inpatient Hospital Services* section of this Manual for specific information.

The MCO shall cover other necessary equipment, repairs, and replacements according to the Durable Medical Equipment Provider Manual chapter of the **Medicaid Services Manual**.

Implantation Procedure, Postoperative Rehabilitative Costs, and Subsequent Therapy

The MCO shall cover the cochlear implant surgery as well as postoperative aural rehabilitation by an audiologist and subsequent speech, language, and hearing therapy.

Post-Operative Programming

The MCO shall cover cochlear implant post-operative programming and diagnostic analysis services.

Concurrent Care – Inpatient

The MCO shall cover inpatient concurrent care when an enrollee's condition requires the care of more than one provider on the same day and the services rendered by each individual provider are medically necessary and not duplicative.

The MCO shall separately reimburse providers from different specialties/subspecialties, whether from the same group or a different group. Each provider from a different specialty/subspecialty can be reimbursed for one initial hospital visit per admission plus a maximum of one subsequent hospital visit per day.

Within the same specialty/subspecialty, only one provider can be reimbursed for one initial hospital visit per admission and, subsequently, only one provider can be reimbursed for a maximum of one subsequent hospital visit per day.

The MCO shall reimburse only the provider responsible for discharging the enrollee for hospital discharge services on the discharge day.

Diabetes Self-Management Training

The MCO shall cover diabetes self-management training (DSMT) services which, at a minimum, must include the following:

- Instructions for blood glucose self-monitoring;
- Education regarding diet and exercise;
- Individualized insulin treatment plan (for insulin dependent enrollees); and
- Encouragement and support for use of self-management skills.

DSMT must be aimed at educating enrollees on the following topics to promote successful self-management:

- Diabetes overview, including current treatment options and disease process;
- Diet and nutritional needs;
- Increasing activity and exercise;
- Medication management, including instructions for self-administering injectable medications (as applicable);
- Management of hyperglycemia and hypoglycemia;
- Blood glucose monitoring and utilization of results;
- Prevention, detection, and treatment of acute and chronic complications associated with diabetes (including discussions on foot care, skin care, etc.);
- Reducing risk factors, incorporating new healthy behaviors into daily life, and setting goals to promote successful outcomes;
- Importance of preconception care and management during pregnancy;
- Managing stress regarding adjustments being made in daily life; and
- Importance of family and social support.

All educational material must be pertinent and age appropriate for each enrollee. Parents or legal guardians can participate in DSMT rendered to their child, but all claims for these services must be submitted under the child's Medicaid coverage.

Provider Qualifications

DSMT is not a separately recognized provider type and the MCO shall require that DSMT services be provided and reimbursed under the direction of a physician, advanced practice registered nurse, or physician assistant.

Accreditation

The MCO shall require providers of DSMT services to be accredited by one of the following national accreditation organizations:

- American Diabetes Association (ADA),
- American Association of Diabetes Educators (AADE), or
- Indian Health Service (IHS).

The MCO shall not cover services provided by providers without proof of accreditation from one of the listed organizations.

At a minimum, providers of DSMT services must include at least one registered dietician, registered nurse, or pharmacist. Each enrollee of the instructional team must be a Certified Diabetes Educator (CDE) or have recent didactic and experiential preparation in education and diabetes management, and at least one member of the instructional team must be a CDE who has been certified by the National Certification Board for Diabetes Educators (NCBDE). The MCO shall require providers to maintain and provide proof of certification of staff members as requested by LDH or its fiscal intermediary.

All DSMT services must adhere to the National Standards for Diabetes Self-Management Education.

Coverage Requirements

The MCO shall cover DSMT for eligible enrollees who have been diagnosed with type 1, type 2, or gestational diabetes mellitus and who have an order from a provider involved in the management of their diabetes, such a primary care provider or obstetrician.

The MCO shall require the ordering provider to maintain a copy of all DSMT orders. Each order must be signed and must specify the total number of hours being ordered, not to exceed the following coverage limitations:

- A **maximum** of 10 hours of initial training (one hour of individual and nine hours of group sessions) are allowed during the first 12-month period beginning with the initial training date.
- A **maximum** of two hours of individual sessions are allowed for each subsequent year.

If special circumstances occur in which the ordering provider determines an enrollee would benefit from individual sessions rather than group sessions, the order must also include a statement specifying that individual sessions would be more appropriate, along with an explanation.

If a DSMT order must be modified, the updated order must be signed by the ordering provider and copies must be retained in the medical record.

Medicaid Enrollees Not Eligible for DSMT

The following enrollees are not eligible for DSMT:

- Enrollees residing in an inpatient hospital or other institutional setting such as an nursing care facility or a residential care facility; and
- Enrollees receiving hospice services.

Initial DSMT

The MCO's policy for initial DSMT shall include the following:

- Initial DSMT may begin after receiving the initial order. DSMT is allowed for a continuous 12- month period following the initial training date. In order for services to be considered initial, the enrollee must not have previously received initial or follow up DSMT.
- The 10 hours of initial training may be provided in any combination of 30-minute increments over the 12-month period. The MCO should not reimburse for sessions lasting less than 30 minutes.
- Group sessions may be provided in any combination of 30-minute increments. Sessions less than 30 minutes are not covered. Each group session must contain between 2-20 enrollees.

Follow-Up DSMT

After receiving 10 hours of initial training, an enrollee shall be eligible to receive a maximum of two hours of follow-up training each year, if ordered. The MCO shall cover additional training for enrollees under age 21 if determined to be medically necessary and documented in the record.

Follow-up training is based on a **12-month calendar year following completion of the initial training**. If an enrollee completes 10 hours of initial training, the enrollee shall be eligible for two hours of follow-up training for the next calendar year. If all 10 hours of initial training are not used within the first calendar year, then the enrollee shall have 12 months to complete the initial training prior to follow up training.

- Example #1:
  - An enrollee receives his or her first training in April and completes the initial 10 hours by April of the next year. The enrollee would be eligible for two hours of subsequent training beginning in May, since that would be the 13th month. If the enrollee completes the two hours of subsequent training in November of that same year, then additional training cannot begin until January (the next calendar year).
- Example #2:
  - An enrollee receives his or her first training in February and exhausts all 10 hours of initial training by November. The enrollee would be eligible for two hours of subsequent training beginning in January. If the enrollee completes the two subsequent hours of training by May, then additional training cannot begin until January of the following year.

Providers are expected to communicate with enrollees to determine if the enrollee has previously received DSMT services or has exhausted the maximum hours of DSMT services for the given year.

The MCO shall cover 10 hours of initial training (for the first 12 months) and two hours of follow-up training (for each subsequent year) regardless of the providers of service.

Provider Responsibilities

Providers must ensure the following conditions are met in order to receive MCO reimbursement:

- The enrollee meets one of the following requirements:
  - Is a newly diagnosed diabetic, gestational diabetic, pregnant with a history of diabetes, or has received no previous diabetes education;
  - Demonstrates poor glycemic control (A1c>7);
  - Has documentation of an acute episode of severe hypoglycemia or hyperglycemia occurring in the past 12 months; or
  - Has received a diagnosis of a complication, a diagnosis of a co-morbidity, or prescription for new equipment such as an insulin pump.
- The provider maintains the following documentation requirements:
  - A copy of the order for DSMT from the enrollee's ordering provider;
  - A comprehensive plan of care documented in the medical record;
  - Start and stop time of services;
  - Clinical notes, documenting enrollee progress;
  - Original and ongoing pertinent lab work;
  - Individual education plan;
  - Assessment of the individual's education needs;
  - Evaluation of achievement of self-management goals;
  - Proof of correspondence with the ordering provider regarding the enrollee's progress; and
  - All other pertinent documentation.

Enrollee records, facility accreditation, and proof of staff licensure, certification, and educational requirements must be kept readily available to be furnished, as requested, to Louisiana Medicaid, its authorized representatives, or the state's Attorney General's Medicaid Fraud Control Unit.

Reimbursement

The MCO shall reimburse for DSMT services based on the Professional Services Fee Schedule, at a minimum. The following Healthcare Common Procedure Coding System (HCPCS) codes or their successors are used to bill DSMT services:

- G0108-Diabetes outpatient self-management training services, individual, per 30 minutes
- G0109-Diabetes self-management training services, group session (two or more) per 30 minutes

NOTE: Services provided to pregnant women with diabetes must be billed with the "TH" modifier.

Early and Periodic Screening, Diagnostic, and Treatment Preventive Services Program

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program is a comprehensive and preventive child health program for individuals under the age of 21. The program consists of two mutually supportive, operational components: (1) ensuring the availability and accessibility of required healthcare services; and (2) helping Medicaid enrollees and their parents or guardians effectively use these resources. The intent of the EPSDT program is to direct attention to the importance of preventive health services and early detection and treatment of identified problems.

Enrollees under 21 years of age are entitled to receive all medically necessary health care, screening, diagnostic services, treatment, and other measures to correct or improve physical or mental conditions (Section 1905(r) of the Social Security Act). The EPSDT benefit is comprehensive in nature and includes coverage of all services described in federal Medicaid statutes and regulations including those that are not covered for adults, not explicitly described in the Contract, not included in the Medicaid FFS fee schedules, and not covered in the Louisiana Medicaid State Plan. The MCO shall consult LDH with any questions about these requirements.

The MCO shall have written procedures for EPSDT preventive services in compliance with 42 C.F.R. Part 441 Subpart B-Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), as well as be in compliance with the Centers for Medicare and Medicaid Services (CMS) State Medicaid Manual, Part 5 – EPSDT. These articles outline the requirements for EPSDT, including assurance that all EPSDT eligible enrollees are notified of EPSDT available services; that necessary screening, diagnostic, and treatment services are available and provided; and that tracking or follow-up occurs to ensure all necessary services were provided to all of the MCO's enrollees under the age of 21.

Screening

Enrollee screening includes medical (including developmental, perinatal depression, and behavioral health), vision, hearing, and dental screenings.

The MCO's policy shall include the following EPSDT screening guidelines, as age appropriate. The MCO shall ensure that these guidelines are followed by its providers.

Periodic Screening

Louisiana Medicaid has adopted the "Recommendations for Preventive Pediatric Health Care" periodicity schedule promulgated by the American Academy of Pediatrics (AAP)/Bright Futures with two exceptions:

- The Louisiana Medicaid EPSDT screening guidelines and policies are for individuals under 21 years of age; and
- Louisiana Medicaid has stricter requirements for lead assessment and blood lead screening in keeping with LAC 48:V.7005-7009. Based on surveillance data gathered by the State Childhood Lead Poisoning Prevention Program and review by the state health officer and representatives from medical schools in the state, all parishes in Louisiana are identified as high risk for lead poisoning.

- The MCO shall ensure children ages six months to 72 months are screened in compliance with Louisiana Medicaid EPSDT requirements and in accordance with practices consistent with current Centers for Disease Control and Prevention guidelines, which include the following specifications:
  - Administer a risk assessment at every well child visit;
  - Use a blood test to screen all children at ages 12 months and 24 months or at any age older than 24 months and up to 72 months, if they have not been previously screened; and
  - Use a venous blood sample to confirm results when finger stick samples indicate blood lead levels ≥5 µg/dl (micrograms per deciliter).
- The MCO's policy must require providers to report a lead case to the Office of Public Health's Childhood Lead Poisoning Prevention Program [link] **within 24 working hours**. A lead case is indicated by a blood lead test result of >5 µg/dl.

The AAP Bright Futures "Recommendations for Preventive Pediatric Health Care" can be found on the American Academy of Pediatrics' website [link].

The MCO shall ensure that providers have access to the most current periodicity schedule and that EPSDT enrollees receive services according to this schedule.

If an abnormality or problem is encountered and treatment is significant enough to require an additional evaluation and management (E&M) service on the same date, by the same provider, no additional E&M of a level higher than CPT code 99212 is reimbursable.

The physician, advanced practice registered nurse (APRN), or physician assistant (PA) listed as the rendering provider must be present and involved during a preventive visit. Any care provided by a registered nurse or other ancillary staff in a provider's office is subject to the policy in the *"Incident to" Services* section of this Manual and must only be providing services within the scope of their license or certification.

Off-Schedule Screening

If a child misses a regular periodic screening, that child may be screened off-schedule in order to bring the child up to date at the earliest possible time. However, all screenings performed on children who are under two years of age must be at least 30 days apart, and those performed on children age two through six years of age must be at least six months apart.

Interperiodic Screening

Interperiodic screenings may be performed if medically necessary. The parent/guardian or any medical provider or qualified health, developmental, or education professional that comes into contact with the child outside the formal healthcare system may request the interperiodic screening.

An interperiodic screening may only be provided if the enrollee has received an age-appropriate preventive medical screening. If the preventive screening has not been performed, then the provider must perform an age-appropriate preventive screening.

An interperiodic screening includes a complete unclothed exam or assessment, health and history update, measurements, immunizations, health education and other age-appropriate procedures.

An interperiodic screening may be performed and billed for a required Head Start physical or school sports physical, but must include all of the components required in the EPSDT preventive periodic screening.

Documentation must indicate that all components of the screening were completed. Medically necessary laboratory, radiology, or other procedures may also be performed and may be billed separately. A well diagnosis is not required.

Preventive Medical Screening

Components of the EPSDT preventive medical screenings include the following:

- A comprehensive health and developmental history (including assessment of both physical and mental health and development);
- A comprehensive unclothed physical exam or assessment;
- Appropriate immunizations according to age and health history (unless medically contraindicated or parents/guardians refuse at the time);
- Laboratory tests* (including age-appropriate screenings for newborns, iron deficiency anemia, blood lead levels, dyslipidemia, and sexually transmitted infections); and
- Health education (including anticipatory guidance).

*The blood lead levels and iron deficiency anemia components of the preventive medical screening must be provided on-site on the same date of service as the screening visit.

The services shall be available both on a regular basis, and whenever additional health treatment or services are needed. EPSDT screenings may identify problems needing other health treatment or additional services.

Neonatal/Newborn Screening for Genetic Disorders

The MCO shall include in its manuals the directive that providers are responsible for obtaining the results of the initial neonatal screening by contacting the hospital of birth, the health unit in the parish of the mother's residence, or through the Office of Public Health (OPH) Genetics Diseases Program's web-based Secure Remote Viewer (SRV) [link].

If screening results are not available, or if newborns are screened prior to 24 hours of age, newborns must have another newborn screen. The newborn infant must be rescreened at the first medical visit after birth, preferably between one and two weeks of age, but no later than the third week of life.

Initial or repeat neonatal screening results must be documented in the medical record for all children less than six months of age. Children over six months of age do not need to be screened unless it is medically indicated. When a positive result is identified from any of the conditions specified in LAC, Book Two of Two: Part V. Preventive Health Services Subpart 18. Disability Prevention Program Chapter 63. Newborn Heel Stick Screening §6303, and a private laboratory is used, the provider must immediately notify the Louisiana OPH Genetics Disease Program.

For newborn screening for severe combined immunodeficiency (SCID), the MCO shall cover testing under CPT code 81479. This code is only to be used for this purpose and until such a time as a permanent procedure code is in place.

Preventive Vision Screening

Subjective Vision Screening

The subjective vision screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of any:

- Eye disorders of the child or the child's family;
- Systemic diseases of the child or the child's family which involve the eyes or affect vision;
- Behavior on the part of the child that may indicate the presence or risk of eye problems; and
- Medical treatment for any eye condition.

Objective Vision Screening

Objective vision screenings may be performed by trained office staff under the supervision of a licensed physician, physician assistant, registered nurse, advanced practice registered nurse, or optometrist. The interpretive conference to discuss findings from the screenings must be performed by a licensed physician, physician assistant, registered nurse, or advanced practice registered nurse.

Vision screening services are to be provided according to the AAP/Bright Futures recommendations.

Preventive Hearing Screening

Subjective Hearing Screening

The subjective hearing screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of:

- The child's response to voices and other auditory stimuli;
- Delayed speech development;
- Chronic or current otitis media; and
- Other health problems that place the child at risk for hearing loss or impairment.

Objective Hearing Screening

The objective hearing screenings may be performed by trained office staff under the supervision of a licensed audiologist or speech pathologist, physician, physician assistant, registered nurse, or advanced practice registered nurse. The interpretive conference to discuss findings from the screenings must be performed by a licensed physician, physician assistant, registered nurse, or advanced practice registered nurse.

Hearing screening services are to be provided according to the AAP/Bright Futures recommendations.

Dental Screening

An oral health risk assessment must be performed per the Bright Futures periodicity schedule.

Refer to the Dental Services Provider Manual chapter of the **Medicaid Services Manual** for additional information pertaining to EPSDT dental services.

Developmental and Autism Screening

The MCO shall cover developmental and autism screenings administered during EPSDT preventive visits in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule. The MCO shall also cover developmental and autism screenings performed by primary care providers when administered at intervals outside EPSDT preventive visits if they are medically indicated for an enrollee at-risk for, or with a suspected, developmental abnormality. The MCO shall include in its manuals the requirements below.

The MCO will only reimburse the use of age-appropriate, caregiver-completed, and validated screening tools as recommended by the AAP.

If an enrollee screens positive on a developmental or autism screen, the provider must give appropriate developmental health recommendations, refer the enrollee for additional evaluation, or both, as clinically appropriate. Providers must document the screening tool(s) used, the result of the screen, and any action taken, if needed, in the enrollee's medical record.

Developmental screening and autism screening are currently reimbursed using the same procedure code. Providers may only receive reimbursement for one developmental screen and one autism screen per day of service. To receive reimbursement for both services performed on the same day, providers may submit claims for 2 units of the relevant procedure code.

Perinatal Depression Screening

The MCO shall cover perinatal depression screening administered to an enrollee's caregiver in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule. The screening can be administered from birth to 1 year during an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) preventive visit, interperiodic visit, or E&M office visit. This service is a recommended, but not required, component of well-child care. The MCO shall include in its manuals the requirements below.

Perinatal depression screening must employ one of the following validated screening tools:

- Edinburg Postnatal Depression Scale (EPDS)
- Patient Health Questionnaire 9 (PHQ-9)
- Patient Health Questionnaire 2 (PHQ-2) and, if positive, a full PHQ-9

Documentation must include the tool used, the results, and any follow-up actions taken. If an enrollee's caregiver screens positive, the provider must refer the caregiver to available resources, such as their primary care provider, obstetrician, or mental health professionals, and document the referral. If screening indicates possible suicidality, concern for the safety of the caregiver or enrollee, or another psychiatric emergency, then referral to emergency mental health services is required.

Though the screening is administered to the caregiver, the MCO shall reimburse this service under the child's Medicaid coverage. If 2 or more children under age 1 present to care on the same day (e.g., twins or other siblings both under age 1), the provider must submit the claim under only one of the children. When performed on the

same day as a developmental screening, providers must append modifier -59 to claims for perinatal depression screening.

Immunizations

The MCO shall include in its manuals the requirements below around immunizations. Appropriate immunizations (unless medically contraindicated or the parents/guardians refuse) are a federally required medical screening component.

The MCO must ensure that all Medicaid-enrolled providers that provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) well child preventive screenings are enrolled in the Vaccines for Children (VFC) program and utilize VFC vaccines for enrollees aged birth through 18 years of age.

The MCO shall ensure that enrollees receive age appropriate immunizations as described above during their periodic or interperiodic preventive visit or other appropriate opportunity. The current Childhood Immunization Schedule recommended by Advisory Committee on Immunizations Practices (ACIP), American Academy of Pediatrics (AAP), and American Academy of Family Physicians (AAFP), which is updated annually, must be followed. Providers are responsible for obtaining current copies of the schedule. The MCO shall ensure that enrollees receive immunizations per the schedule.

NOTE: Refer to the *Immunizations* section of this Manual for additional information.

Laboratory

The MCO shall include in its manuals the requirements below around laboratory screening. Age-appropriate laboratory tests are required at selected age intervals. Documented laboratory procedures provided less than six months prior to the medical screening must not be repeated unless medically necessary**.** Iron deficiency anemia and blood lead testing when required are included in the medical screening fee and must not be billed separately.

Diagnosis and Treatment

Screening services are performed to ensure that health problems are found, diagnosed, and treated early before becoming more serious and additional treatment is necessary. Providers are responsible for identifying any general suspected conditions and reporting the presence, nature, and status of the suspected conditions.

The MCO's policy shall include the following diagnosis and treatment guidelines. The MCO shall ensure that these guidelines are followed by its providers.

Diagnosis

When a screening indicates the need for further diagnosis or evaluation of a child's health, the child must receive a complete diagnostic evaluation within 60 days of the screening or sooner as medically necessary.

The MCO's policy shall require the provider to make any necessary referrals of the enrollee to a specialist. The MCO shall maintain a referral system with an adequate provider network to support the provider in making the referrals and to support the enrollee in accessing the services. It is responsibility of the MCO to ensure that the enrollee receives the diagnostic services required.

Initial Treatment

Medically necessary health care, initial treatment, or other measures needed to correct or ameliorate physical or mental illnesses or conditions discovered in a medical, vision, or hearing screening must be initiated within 60 days of the screening or sooner if medically necessary.

Providing or Referring Enrollees for Services

Providers detecting a health or mental health problem in a screening must either provide the services indicated or refer the enrollee for care. Providers who perform the diagnostic and/or initial treatment services should do so at the screening appointment when possible, but must ensure that enrollees receive the necessary services within 60 days of the screening or sooner if medically necessary.

Providers who refer the enrollee for care must make the necessary referrals at the time of screening. This information must be maintained in the enrollee's record.

The MCO's policy shall require the provider to make any necessary referrals of the enrollee to a specialist. The MCO shall maintain a referral system with an adequate provider network to support the provider in making the referrals and to support the enrollee in accessing the services. It is the responsibility of the MCO to ensure that the enrollee receives the treatment services required.

Dental Treatment

Fluoride Varnish Application

Fluoride varnish applications are covered when provided in a physician office setting (including RHCs and FQHCs) once every six months for enrollees six months through five years of age. Providers eligible for reimbursement of this service include physicians, physician assistants, and nurse practitioners who have reviewed the Smiles for Life fluoride varnish training module [link] and successfully completed the post assessment. Physicians are responsible to provide and document training to their participating staff to ensure competency in fluoride varnish applications.

Fluoride varnish applications may only be applied by the following disciplines:

- Appropriate dental providers;
- Physicians;
- Physician assistants;
- Nurse practitioners;
- Registered nurses;
- Advanced practice registered nurses;
- Licensed practical nurses; or
- Certified Medical Assistants.

NOTE: Refer to the Dental Services Provider Manual chapter of the **Medicaid Services Manual** for information pertaining to EPSDT Fluoride Varnish Application.

EarlySteps Program

The EarlySteps Program provides services to families with infants and toddlers aged birth to three years who have a medical condition likely to result in a developmental delay, or who have developmental delays.

The MCO shall ensure that any infant or toddler who meets or may meet the medical or biological eligibility criteria for EarlySteps (infant and toddler early intervention services) is referred to the local EarlySteps Program.

Additional information about the EarlySteps Program may be found on the LDH webpage [link].

Eye Care and Vision Services

The MCO shall not require a referral for in-network providers.

The MCO's requirements for provision and authorization of services within the scope of licensure for optometrists cannot be more stringent than those requirements for participating ophthalmologists.

Family Planning Services

The MCO shall cover family planning services, including, but not limited to:

- Comprehensive medical history and physical exam at least once per year. This visit includes anticipatory guidance and education related to enrollees' reproductive health/needs;
- Contraceptive counseling to assist enrollees in reaching an informed decision (including natural family planning, education follow-up visits, and referrals);
- Laboratory tests routinely performed as part of an initial or regular follow-up visit/exam for family planning purposes and management of sexual health;
- Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may also be covered;
- Pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the Federal Food and Drug Administration;
- Male and female sterilization procedures provided in accordance with 42 C.F.R. Part 441, Subpart F;
- Treatment of major complications from certain family planning procedures such as: treatment of perforated uterus due to intrauterine device insertion; treatment of severe menstrual bleeding caused by a medroxyprogesterone acetate injection requiring dilation and curettage; and treatment of surgical or anesthesia-related complications during a sterilization procedure; and
- Transportation services to and from family planning appointments provided all other criteria for Non-Emergency Medical Transportation (NEMT) are met.

Family planning services shall also include diagnostic evaluation, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy, detection, or treatment of sexually transmitted infections (STIs), and age-appropriate vaccination for the prevention of HPV and cervical cancer. Prior authorization shall not be required for treatment of STIs.

The MCO shall address high STI prevalence by incentivizing providers to conduct screening, prevention education and early detection, including targeted outreach to at risk populations.

The MCO shall ensure that its enrollees have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions, as specified in 42 C.F.R. §431.51(b)(2). The out-of-network Medicaid-enrolled family planning services provider shall bill the MCO and be reimbursed no less than the FFS rate in effect on the date of service.

The MCO shall encourage its enrollees to receive family planning services through the MCO's network of providers to ensure continuity and coordination of an enrollee's total care. No additional reimbursements shall be made to the MCO for its enrollees who elect to receive family planning services outside the MCO's provider network.

The MCO shall encourage family planning providers to communicate with the enrollee's PCP once any form of medical treatment is undertaken.

The MCO shall maintain accessibility for family planning services through promptness in scheduling appointments (appointments available within one week).

The MCO shall not provide assisted reproductive technology for treatment of infertility.

Genetic Counseling and Testing

Genetic testing for a particular disease should generally be performed once per lifetime; however, there are rare instances in which testing may be performed more than once in a lifetime (e.g., previous testing methodology is inaccurate or a new discovery has added significant relevant mutations for a disease).

Genetic Counseling

The MCO shall require counseling before and after all genetic testing. Counseling must consist of at least all of the following and be documented in the enrollee's medical record:

- Obtaining a structured family genetic history;
- Genetic risk assessment; and
- Counseling of the enrollee and family about diagnosis, prognosis, and treatment.

When performed by licensed genetic counselors, the MCO shall reimburse services using the procedure code specific to genetic counseling. Reimbursement for this service is "incident to" the services of a supervising physician and is limited to no more than 90 minutes on a single day of service.

When performed by providers other than licensed genetic counselors, the MCO shall reimburse for counseling under an applicable evaluation and management code.

Breast and Ovarian Cancer

The MCO shall cover and consider genetic testing for *BRCA1* and *BRCA2* mutations in cancer-affected individuals and cancer-unaffected individuals to be medically necessary if the enrollee meets the criteria listed below.

Eligibility Criteria

Individuals meeting one or more of the below criteria are considered eligible.

- Individuals with any blood relative with a known *BRCA1*/*BRCA2* mutation;
- Individuals meeting the criteria below but with previous limited testing (e.g., single gene and/or absent deletion duplication analysis) interested in pursuing multi-gene testing;
- Individuals with a personal history of cancer, defined as one or more of the following:
    - Breast cancer and one or more of the following:
        - Diagnosed age ≤ 45 years; or
        - Diagnosed at age 45—50 years with:
            - Unknown or limited family history; or
            - A second breast cancer diagnosed at any age; or
            - ≥ 1 close blood relative* with breast, ovarian, pancreatic, or high-grade (Gleason score ≥ 7) or intraductal prostate cancer at any age
        - Diagnosed at age ≤ 60 years with triple negative (ER–, PR–, HER2–) breast cancer;
        - Diagnosed at any age with:
            - Ashkenazi Jewish ancestry; or
            - ≥1 close blood relative* with breast cancer at age ≤ 50 years or ovarian, pancreatic, or metastatic or intraductal prostate cancer at any age; or
            - ≥3 total diagnoses of breast cancer in patient and/or close blood relatives*
        - Diagnosed at any age with male breast cancer; or
        - Epithelial ovarian cancer (including fallopian tube cancer or peritoneal cancer) at any age;
    - Exocrine pancreatic cancer at any age;
    - Metastatic or intraductal prostate cancer at any age;
    - High-grade (Gleason score ≥ 7) prostate cancer at any age with:
        - Ashkenazi Jewish ancestry; or
        - ≥1 close blood relative* with breast cancer at age ≤ 50 years or ovarian, pancreatic, or metastatic or intraductal prostate cancer at any age; or
        - ≥2 close blood relatives* with breast or prostate cancer (any grade) at any age
    - A mutation identified on tumor genomic testing that has clinical implications if also identified in the germline
    - To aid in systemic therapy decision-making, such as for HER2-negative metastatic breast cancer
- Individuals with a family history of cancer, including unaffected individuals, defined as one or more of the following:
    - An affected or unaffected individual with a 1st- or 2nd-degree blood relative meeting any of the criterion listed above (except individuals who meet criteria only for systemic therapy decision-making); or
    - An affected or unaffected individual who otherwise does not met criteria above but also has a probability > 5% of a *BRCA1/2* pathogenic variant based on prior probability models (e.g., Tyer-Cuzick, BRCAPro, Pennll)

*For the purpose of familial assessment, close blood relatives include first-, second-, and third-degree relatives on the same side of the family (maternal or paternal):

- 1st-degree relatives are parents, siblings, and children;
- 2nd-degree relatives are grandparents, aunts, uncles, nieces, nephews, grandchildren, and half siblings; or
- 3rd-degree relatives are great-grandparents, great-aunts, great-uncles, great grandchildren and first cousins.

Familial Adenomatous Polyposis

FAP is caused by a hereditary genetic mutation in the APC tumor suppressor gene which leads to development of adenomatous colon polyps.

The MCO shall cover and consider genetic testing for adenomatous polyposis coli (APC) gene mutations to diagnose familial adenomatous polyposis (FAP) to be medically necessary if the enrollee meets the following criteria.

Eligibility Criteria

- Personal history of ≥ 20 cumulative adenoma; or
- Known deleterious APC mutation in first-degree family member.

Lynch Syndrome

The MCO shall cover and consider genetic testing for Lynch syndrome to be medically necessary when an enrollee meets the following criteria:

- Amsterdam II criteria; or
- Revised Bethesda Guidelines; or
- Estimated risk ≥ 5% based on predictive models (MMRpro, PREMM5, or MMRpredict).

Amsterdam II Criteria

There must be at least three relatives with a Lynch Syndrome associated cancer (cancer of the colorectal, endometrium, small bowel, ureter or renal pelvis) and all of the following criteria should be present:

- One must be a first-degree relative to the other two;
- Two or more successive generations must be affected;
- One or more must be diagnosed before 50 years of age;
- Familial adenomatous polyposis should be excluded in the colorectal cancer; and
- Tumors must be verified by pathological examination.

Revised Bethesda Guidelines

One or more criterion must be met:

- Colorectal or uterine cancer diagnosed in a patient who is less than 50 years of age;
- Presence of synchronous (coexist at the same time), metachronous (previous or recurring) colorectal cancer, or other Lynch Syndrome associated tumors**;
- Colorectal cancer with the MSI-H*** histology**** diagnosed in a patient who is less than 60 years of age;
- Colorectal cancer diagnosed in one or more first-degree relatives with a Lynch syndrome related tumor, with one of the cancers being diagnosed under 50 years of age; and/or
- Colorectal cancer diagnosed in two or more first- or second-degree relatives with Lynch syndrome related tumors, regardless of age.

**Hereditary nonpolyposis colorectal cancer (HNPCC)-related tumors include colorectal, endometrial, stomach, ovarian, pancreas, ureter and renal pelvis, biliary tract, and brain (usually glioblastoma as seen in Turcot syndrome) tumors, sebaceous gland adenomas and keratoacanthomas in Muir-Torre syndrome, and carcinoma of the small bowel.

***MSI-H - microsatellite instability–high in tumors refers to changes in two or more of the five National Cancer Institute-recommended panels of microsatellite markers

****Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern.

Gynecology

Gynecologic services include:

- Hysterectomies;
- Long-acting reversible contraceptives;
- Mammograms;
- Pap smears;
- Pelvic examinations; and
- Saline infusion sonohysterography or hysterosalpingography.

Hysterectomies

Federal regulations governing Medicaid reimbursement of hysterectomies prohibit reimbursement under the following circumstances:

- The hysterectomy is performed solely for the purpose of terminating reproductive capability; or
- There is more than one purpose for performing the hysterectomy, but the procedure would not be performed except for the purpose of rendering the individual permanently incapable of reproducing.

The MCO shall only cover a hysterectomy when:

- The person securing authorization to perform the hysterectomy has informed the individual and her representative (if any), both orally and in writing, that the hysterectomy will make the individual permanently incapable of reproducing; and
- The individual or their representative (if any) has signed a written acknowledgement of receipt of that information.

These regulations apply to all hysterectomy procedures, regardless of the enrollee's age, fertility, or reason for surgery.

Consent for Hysterectomy

The MCO's policy for obtaining consent for hysterectomies shall include the following:

- The Acknowledgement of Receipt of Hysterectomy Information (hysterectomy consent form)[9] must be signed and dated by the enrollee on or before the date of the hysterectomy. The consent must include signed acknowledgement from the enrollee stating the enrollee has been informed orally and in writing that the hysterectomy will make the enrollee permanently incapable of reproducing. Enrollees who undergo a covered hysterectomy must complete a hysterectomy consent form but are not required to complete a sterilization consent form.
- The physician who obtains the consent must share the consent form with all providers involved in that enrollee's care (e.g., attending physician, hospital, anesthesiologist, and assistant surgeon).
- When billing for services that require a hysterectomy consent form, the name on the Medicaid file for the date of service in which the form was signed should be the same as the name signed at the time consent was obtained. If the enrollee's name is different, the provider must attach a letter from the physician's office from which the consent was obtained. The letter must be signed by the physician and must state that the enrollee's name has changed and must include the enrollee's social security number and date of birth. This letter must be attached to all claims requiring consent upon submission for claims processing.
- A witness signature is needed on the hysterectomy consent when the enrollee meets one of the following criteria:
    - Enrollee is unable to sign their name and must indicate "x" on the signature line; or
    - There is a diagnosis on the claim that indicates mental incapacity.
- If a witness signs the consent form, the signature date must match the date of the enrollee's signature. If the dates do not match, or the witness does not sign and date the form, claims related to the hysterectomy will deny.

Exceptions

Obtaining consent for a hysterectomy is unnecessary in the following circumstances:

- The individual was already sterile before the hysterectomy, and the physician who performed the hysterectomy certifies that the individual was already sterile at the time of the hysterectomy and states the cause of sterility.
- The individual required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible, and the physician certifies in his own writing that the hysterectomy was performed under these conditions and includes in his narrative a description of the nature of the emergency.
- The individual was retroactively certified for Medicaid benefits, and the physician who performed the hysterectomy certifies in his own writing that the individual was informed before the operation that the hysterectomy would make the enrollee permanently incapable of reproducing. In addition, if the individual was certified retroactively for benefits, and the hysterectomy was performed under one of the two other conditions listed above, the physician must certify in writing that the hysterectomy was

[9] The current hysterectomy consent form (BHSF Form 96-A), with instructions, is available at www.lamedicaid.com under the directory link "Forms/Files/Surveys/User Manuals" [link]. The BHSF Form 96-A revised 02/2020 is effective with dates of service on and after May 1, 2020 and replaces the BHSF Form 96-A revised 05/06. MCOs shall grant providers a grace period from May 1, 2020 until May 31, 2020, during which either form will be accepted. Effective with dates of service on and after June 1, 2020, only BHSF Form 96-A revised 02/2020 may be accepted.

performed under one of those conditions and that the enrollee was informed, in advance, of the reproductive consequences of having a hysterectomy.

Reimbursement

Prior to reimbursement, the MCO shall ensure that the hysterectomy consent form or a physician's written certification (see *Exceptions* section) is obtained. The MCO shall allow ancillary providers and hospitals to submit claims without the hard copy consent. The MCO shall reimburse these providers only if the provider performing the hysterectomy submitted a valid hysterectomy consent and was reimbursed for the procedure.

The MCO is responsible for maintaining required documentation and shall not shred documentation without prior approval by LDH.

Long-Acting Reversible Contraceptives

The MCO shall cover the insertion and removal of all FDA approved long-acting reversible contraceptives.

Screening Mammography

The MCO shall cover one screening mammogram per calendar year for females at least 40 years of age.

Papanicolaou Testing for Cervical Cancer

Based on American College of Obstetricians and Gynecologists (ACOG) guidelines regarding Papanicolaou testing (Pap tests), the MCO shall not routinely cover testing for enrollees under 21 years of age.

Eligibility Criteria (for those under age 21)

The MCO shall consider cervical cancer screening (including repeat screening) medically necessary for enrollees under 21 years of age if they meet the following criteria:

- Were exposed to diethylstilbestrol before birth;
- Have human immunodeficiency virus;
- Have a weakened immune system;
- Have a history of cervical cancer or abnormal cervical cancer screening test; or
- Meet other criteria subsequently published by ACOG.

Reimbursement

The MCO shall include the collection of cytopathologic vaginal test (Pap test) specimens in the reimbursement of the evaluation and management services.

For those enrollees under the age of 21, the MCO shall require the treating provider to submit the required documentation needed for billing to the laboratory provider.

Pelvic Examinations

The MCO shall cover routine pelvic examinations in the reimbursement for the evaluation and management service. Therefore, the MCO shall not allow routine pelvic examinations to be billed as separate procedures.

Pelvic examinations under anesthesia may be medically necessary for certain populations. The MCO shall require the provider to indicate the medical justification for the pelvic examination under anesthesia in the enrollee's medical record.

Saline Infusion Sonohysterography or Hysterosalpingography

The MCO shall cover saline infusion sonohysterography or hysterosalpingography, limited to the assessment of fallopian tube occlusion or ligation following a sterilization procedure.

Home Health Services

A home health agency (HHA) provides patient care services in the enrollee's residential setting, under the order of a physician, that are necessary for the diagnosis and treatment of the enrollee's illness or injury. Such services include part-time skilled nursing services, extended skilled nursing services (for enrollees under 21 years of age), home health aide services, physical therapy (PT), speech therapy (ST), occupational therapy (OT), and medical supplies recommended by the physician as required in the care of the enrollee and suitable for use in any setting in which normal life activities take place.

The MCO shall cover the following home health services:

- Skilled nursing (intermittent or part-time);
- Home health aide services, in accordance with the plan of care (POC) as recommended by the attending physician;
- Extended skilled nursing services (also referred to as extended home health), as part of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, is extended nursing care by a registered nurse or a licensed practical nurse (LPN) and may be provided to enrollees under age 21 who are considered "medically fragile";
- Rehabilitation services are physical, occupational and speech therapies, including audiology services; and
- Medical supplies, equipment, and appliances, as recommended by the physician, required in the POC for the enrollee and suitable for use in any setting in which normal life activities take place are covered under the Durable Medical Equipment (DME) program and must be prior authorized.

The MCO shall ensure that a face-to-face encounter between the patient and the physician or an allowed non-physician provider (NPP) occur no more than 90 days prior to, or 30 days after, admission to the home health agency.

Hyperbaric Oxygen Therapy

The MCO shall cover hyperbaric oxygen therapy treatments administered in a hyperbaric oxygen therapy chamber for the following conditions, if deemed medically necessary:

- Acute carbon monoxide intoxication;

- Decompression illness;
- Gas embolism;
- Gas gangrene;
- Acute traumatic peripheral ischemia. Hyperbaric oxygen therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened;
- Crush injuries and suturing of severed limbs. Hyperbaric oxygen therapy would be an adjunctive treatment when loss of function, limb, or life is threatened;
- Progressive necrotizing infections (necrotizing fasciitis);
- Acute peripheral arterial insufficiency;
- Preparation and preservation of compromised skin grafts (not for primary management of wounds);
- Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management;
- Osteoradionecrosis as an adjunct to conventional treatment;
- Soft tissue radionecrosis as an adjunct to conventional treatment;
- Cyanide poisoning;
- Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment; and
- Diabetic wounds of the lower extremities when:
    - The wound is classified as Wagner grade 3 or higher; and
    - An adequate course of standard wound therapy was not sufficient to lead to healing.

Immunizations

For enrollees age 18 and younger, the MCO shall only cover vaccine administration for immunizations recommended by the Advisory Committee on Immunization practices (ACIP). Vaccines for enrollees age 18 and younger are provided free of charge through the Louisiana Immunization Program/Vaccines for Children program, as described below.

For enrollees age 19 and older, the MCO shall cover all ACIP-recommended vaccines, and vaccine administration, according to ACIP recommendations and without restrictions or prior authorization.

NOTE: Refer to the *EPSDT Preventive Services Program* section of this Manual for additional information.

Combination Vaccines

The MCO shall encourage combination vaccines in order to maximize the opportunity to immunize and to reduce the number of injections a child receives in one day. The MCO shall not reimburse providers for a single-antigen vaccine and its administration if a combined-antigen vaccine is medically appropriate and the combined vaccine is approved by the Secretary of the U.S. Department of Health and Human Services.

Louisiana Immunization Program/Vaccines for Children Program

The MCO must ensure that all Medicaid-enrolled providers that provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) well child preventive screenings are enrolled in the Vaccines for Children (VFC) program and utilize VFC vaccines for enrollees aged birth through 18 years of age.

Providers can obtain a VFC enrollment packet by calling the Office of Public Health's (OPH) Immunization Section [link] at (504) 568-2600.

Reimbursement

The MCO shall require providers to indicate the CPT code for the specific vaccine in addition to the appropriate administration CPT code(s) to receive reimbursement for the administration of appropriate immunizations. The listing of the vaccine on the claim form is required for federal reporting purposes.

Vaccines from the Vaccines for Children Program are available at no cost to the provider and are required to be used for Medicaid enrollees through 18 years of age. Therefore, the MCO shall reimburse CPT codes for vaccines available from the VFC Program at zero ($0) for every enrollee from birth through 18 years of age.

Declared Pediatric Flu Vaccine Shortage Plan

The MCO's policy shall include the following provisions regarding flu vaccine shortages:

- If a Medicaid provider does not have the VFC pediatric influenza vaccine on hand to vaccinate a **high priority** Medicaid-enrolled child, the provider should not turn away, refer or reschedule the enrollee for a later date if the vaccine is available from private stock. The provider should use pediatric influenza vaccine from private stock and replace the dose(s) used from private stock with dose(s) from VFC stock when the VFC vaccine becomes available.
- If a Medicaid provider does not have the VFC pediatric influenza vaccine on hand to vaccinate a **non-high priority or non-high risk** Medicaid-enrolled child, the enrollee can:
    - Wait for the VFC influenza vaccine to be obtained, or
    - If the enrollee chooses not to wait for the VFC influenza vaccine to be obtained, and the provider has private stock of the vaccine on hand, the MCO shall reimburse only the administration of the private stock vaccine.
        - If the provider intends to charge the enrollee for the vaccine, then prior to the injection, the provider shall inform the enrollee/guardian that the actual vaccine does not come from the VFC program and the enrollee will be responsible for the cost of the vaccine. In these situations, the provider shall obtain signed documentation that the enrollee is responsible for reimbursement of the vaccine only.

Louisiana Immunization Network (LINKS)

Louisiana Immunization Network (LINKS) is a computer-based system designed to track immunization records for providers and their patients by:

- Consolidating immunization information among all healthcare providers,
- Assuring adequate immunization coverage levels, and
- Avoiding duplicative immunizations.

The MCO should access LINKS directly to obtain immunization reports. LINKS can be accessed through the OPH website [link].

The MCO shall ensure that providers report the required immunization data into LINKS.

"Incident to" Services

"Incident to" services means services or supplies that are furnished as an integral, although incidental, part of a supervising provider's professional services. For physicians, "incident to" services include those provided by auxiliary personnel (e.g., medical assistants, licensed practical nurses, registered nurses, etc.), but exclude those provided by an advanced practice registered nurse (APRN) and physician assistant (PA). For APRNs and PAs, "incident to" services also include those provided by auxiliary personnel. For all "incident to" services, auxiliary personnel must only operate within the scope of practice of their license or certification.

Provider supervision must consist of either personal participation in the service or direct supervision coupled with review and approval of the service notes. Direct supervision is defined as the provider being present in the facility, though not necessarily present in the room where the service is being rendered, and immediately available to provide assistance and direction throughout the time the service is performed. For Office of Public Health clinics, providers must furnish general supervision, defined as under the supervising provider's overall direction and control, but the provider's presence is not required in the facility during the performance of the service.

When an APRN or PA provides all parts of the service independent of a supervising or collaborating physician's involvement, even if a physician signs off on the service or is present in the facility, the service does not meet the requirements of "incident to" services. Instead, claims for such services must be submitted using the APRN or PA as the rendering provider.

It is inappropriate for a physician to submit claims for services provided by an APRN or PA with the physician listed as the rendering provider when the physician is only supervising, reviewing, or "signing off" on the APRN's or PA's records. Services billed in this manner are subject to post-payment review, recoupment, and additional sanctions as deemed appropriate by Louisiana Medicaid.

Intrathecal Baclofen Therapy

The MCO shall cover surgical implantation of a programmable infusion pump for the delivery of intrathecal baclofen (ITB) therapy for individuals four years of age and older who meet medical necessity for the treatment of severe spasticity of the spinal cord or of cerebral origin.

The following diagnoses are considered appropriate for ITB treatment and infusion pump implantation:

- Meningitis;
- Encephalitis;
- Dystonia;
- Multiple sclerosis;
- Spastic hemiplegia;
- Infantile cerebral palsy;
- Other specified paralytic syndromes;
- Acute, but ill-defined, cerebrovascular disease;
- Closed fracture of the base of skull;
- Open fracture of base of skull;
- Closed skull fracture;
- Fracture of vertebral column with spinal cord injury;

- ❖ Intracranial injury of other and unspecified nature; or
- ❖ Spinal cord injury without evidence of spinal bone injury.

Criteria for Enrollee Selection

Implantation of an ITB infusion pump is considered medically necessary, when the candidate is four years of age or older with a body mass sufficient to support the implanted system, and one or more of the following criteria is met:

- ❖ Inclusive Criteria for Candidates with Spasticity of Cerebral Origin
  - o There is severe spasticity of cerebral origin with no more than mild athetosis;
  - o The injury is older than one year;
  - o There has been a drop in Ashworth scale of 1 or more;
  - o Spasticity of cerebral origin is resistant to conservative management; or
  - o The candidate has a positive response to test dose of ITB.
- ❖ Inclusive Criteria for Candidates with Spasticity of Spinal Cord Origin
  - o Spasticity of spinal cord origin that is resistant to oral antispasmodics or side effects unacceptable in effective doses;
  - o There has been a drop in Ashworth scale of 2 or more; or
  - o The candidate has a positive response to test dose of intrathecal baclofen.

Caution should be exercised when considering ITB infusion pump implantation for candidates who:

- ❖ Have a history of autonomic dysreflexia;
- ❖ Suffer from psychotic disorders;
- ❖ Have other implanted devices; or
- ❖ Utilize spasticity to increase function such as posture, balance, and locomotion.

Exclusion Criteria for Candidates

Consideration shall not be made if the candidate:

- ❖ Fails to meet any of the inclusion criteria;
- ❖ Is pregnant, or refuses or fails to use adequate methods of birth control;
- ❖ Has a severely impaired renal or hepatic function;
- ❖ Has a traumatic brain injury of less than one year pre-existent to the date of the screening dose;
- ❖ Has history of hypersensitivity to oral baclofen;
- ❖ Has a systematic or localized infection which could infect the implanted pump; or
- ❖ Does not respond positively to a 50, 75, or 100 mcg intrathecal bolus of baclofen during the screening trial procedure.

The MCO shall cover outpatient bolus injections given to candidates for the ITB infusion treatment if medically necessary even if the enrollee fails the screening trial procedure.

LSU Enhanced Professional Service Fees

LSU professional service providers receive an enhanced fee for certain codes. The only codes that are to be paid at these enhanced rates are those specific code and specific type of service combinations that are listed on the LSU Enhanced Professional Services Fee Schedules.

If the code and the type of service code are not listed on the enhanced fee schedules, then the minimum rate reimbursed to these LSU providers would be based on the Louisiana Medicaid Professional Services Fee Schedule.

There are two different LSU reimbursement groups:

- Group 1: LSU Essential Provider – Shreveport. This group includes providers:
  - # 2430769, NPI 1013374222, TAX ID 364774713
- Group 2: LSU Essential Provider – New Orleans. This group includes providers:
  - # 1038296, NPI 1992975775, TAX ID 261531455
  - # 1940046, NPI 1558303420, TAX ID 726000749
  - # 1167347, NPI 1477582526, TAX ID 721304948
  - # 1169269, NPI 1477582526, TAX ID 721304948
  - # 1177130, NPI 1932492626, TAX ID 452297609
  - # 1945846, NPI 1477582526, TAX ID 721304948
  - # 2436473, NPI 1275984973, TAX ID 812574422
  - # 2518755, NPI 1285285510, TAX ID 841945250

Each reimbursement group has its own special reimbursement assigned which is outlined on the LSU Enhanced Professional Services Fee Schedules.

Modifiers

The modifiers in the table in this section indicate modifiers that impact reimbursement or policy to establish minimum reimbursement amounts. The below is an exclusive list of modifiers allowed for the purposes of establishing minimum reimbursement rates. The MCO may not mandate the use of modifiers that result in a reimbursement rate that is below the rate established by the fee schedules and these allowed modifiers.

Modifier	Use/Example	Special Billing Instructions	Minimum Reimbursement
22 Unusual Service	Service provided is greater than that which is usually required (e.g., delivery of twins); not to be used with visits or lab codes		125% of the fee on file or billed charges whichever is lower
24 Unrelated evaluation and management service by the same physician during the post-op period			Lower of billed charges or fee on file
25 Significant, separately identifiable evaluation and		When a suspected condition identified during a screening visit and diagnosed/treated by the screening provider during the	Lower of billed charges or fee on file

management service by the same physician on the same day of a procedure or other service		same visit, only lower level E&M appended with modifier 25 allowable; otherwise claim will deny Improper use of modifiers to maximize reimbursement and to bypass valid claims editing will subject the provider to administrative sanctions and/or possible exclusion from the Louisiana Medicaid program.	
26 Professional Component	Professional portion only of a procedure that typically consists of both a professional and a technical component (e.g., interpretation of laboratory or x-ray procedures performed by another provider)		Lower of billed charges or 40% of the fee on file
TC Technical Component		MCOs may not reimburse the technical component only on laboratory and radiology claims. Reimbursement is not allowed for both the professional component and full service on the same procedure.	
50 Bilateral Procedure			Lower of billed charges or 150% of the fee on file
51 Multiple Procedures			Lower of billed charges or 100% of the fee on file for primary/ 50% of the fee on file for all others
52 Reduced Services			Lower of billed charges or 75% of the fee on file
53 Discontinued Procedure	Only for use by Free Standing Birthing Centers (FSBC's) when the enrollee is transferred prior to delivery		50% of the FSBC's facility fee or billed charges, whichever is lower
54 Surgical Care Only	Surgical procedure performed by physician when another physician provides pre- and/or postoperative management		Lower of billed charges or 70% of the fee on file
55 Postoperative Management Only	Postoperative management only when another physician has performed the surgical procedure		Lower of billed charges or 20% of the fee on file
56 Preoperative Management Only	Preoperative management only when another physician		Lower of billed charges or 10% of the fee on file

	has performed the surgical procedure		
NOTE: If full service payment is made for a procedure (i.e., the procedure is billed and paid with no modifier), additional payment will not be made for the same procedure for surgical care only, post-operative care only, or preoperative care only. In order for all providers to be paid in the case when modifiers -54, -55, and -56 would be used, each provider must use the appropriate modifier to indicate the service performed. Claims that are incorrectly billed and paid must be adjusted using the correct modifier in order to allow payment of other claims billed with the correct modifier.			
57 *Evaluation and management service resulting in the initial decision to perform the surgery*			Lower of billed charges or fee on file
59 *Distinct procedural services performed; separate from other services rendered on the same day by the same provider*		Improper use of modifiers to maximize reimbursement and to bypass valid claims editing will subject the provider to administrative sanctions and/or possible exclusion from the Louisiana Medicaid program.	Lower of billed charges or fee on file
62 *Two Surgeons*			Lower of billed charges or 80% of the fee on file for each surgeon.
63 *Infants less than 4 kg*			Lower of billed charges or 125% of the fee on file
66 *Surgical Team*	Performance of highly complex procedure requiring the concomitant services of several physicians (e.g., organ transplant)	Documentation must clearly indicate the name of each surgeon and the procedures performed by each.	Lower of billed charges or 80% of the fee on file for each surgeon.
NOTE: In order for correct payment to be made in the case of two surgeons or a surgical team, all providers involved must bill correctly using appropriate modifiers. If full service payment is made for a procedure (i.e., the procedure is billed and paid with no modifier), additional payment will not be made for the same procedure for two surgeons or surgical team. Payment will not be made for any procedure billed for both full service (no modifier) and for two surgeons or surgical team. If even one of the surgeons involved bills with no modifier and is paid, no additional payment will be made to any other surgeon for the same procedure. Claims which are incorrectly billed with no modifier and are paid must be adjusted using the correct modifier in order to allow payment of other claims billed with the correct modifier.			
79 *Unrelated procedure or service by the same physician during the postoperative period*			Lower of billed charges or fee on file
80 *Assistant Surgeon (MD)*			Lower of billed charges or: MD's - 20% of the full service physician fee on file.
AS *Assistant at Surgery (Physician Assistant or APRN)*			Lower of billed charges or 80% of MD's 'Assistant Surgeon' fee
*NOTE: *The list of codes acceptable with the 80/AS modifier is posted on the Louisiana Medicaid website.*			

AT *Acute Treatment*	Chiropractors use this modifier		Lower of billed charges or fee on file
95 *Telemedicine*	Services provided via a telecommunications system, see the Telemedicine/Telehealth section	Modifier shall be appended to claims for all services provided via telemedicine/telehealth	Lower of billed charges or 100% of the fee on file
Q5 *Reciprocal Billing Arrangement*	Services provided by a substitute physician on an occasional reciprocal basis not over a continuous period of longer than 60 days. Does not apply to substitution within the same group.	The regular physician submits the claim and receives reimbursement for the substitute. The record must identify each service provided by the substitute.	Lower of billed charges or 100% of the fee on file
Q6 *Locum Tenens*	Services provided by a substitute physician retained to take over a regular physician's practice for reasons such as illness, pregnancy, vacation, or continuing education. The substitute is an independent contractor typically paid on a per diem or fee-for- time basis and does not provide services over a period of longer than 60 days.	The regular physician submits claims and receives reimbursement for the substitute. The record must identify each service provided by the substitute	Lower of billed charges or 100% of the fee on file
TH *Prenatal Services*			Lower of billed charges or fee for prenatal services
QW *Laboratory*	Required when billing certain laboratory codes		Lower of billed charges or fee on file

Site Specific Modifiers

Unless specifically indicated otherwise in CPT, providers should use site-specific modifiers to accurately document the anatomic site where procedures are performed when appropriate for the clinical situation.

E1	Upper left, eyelid Lower left, eyelid	LT*	Left side
E2	Upper right, eyelid	RT*	Right side
E3	Lower right, eyelid	LC	Left circumflex, coronary artery
E4	Left hand, thumb	RC	Right coronary artery
FA	Left hand, second digit	LD	Left anterior descending coronary artery
F1	Left hand, third digit	TA	Left foot, great toe
F2	Left hand, fourth digit	T1	Left foot, second digit
F3	Left hand, fifth digit	T2	Left foot, third digit
F4	Right hand, thumb	T3	Left foot, fourth digit
F5	Right hand, second digit	T4	Left foot, fifth digit
F6	Right hand, third digit	T5	Right foot, great toe
F7	Right hand, fourth digit	T6	Right foot, second digit
F8	Right hand, fifth digit	T7	Right foot, third digit
F9	Upper left, eyelid Lower left, eyelid	T8	Right foot, fourth digit
		T9	Right foot, fifth digit

***** When "bilateral" is part of the procedure code description, **RT/LT or -50 shall not be used.**

Multiple Surgical Reduction Reimbursement

Multiple surgery reduction is the general industry term applied to the practice of reimbursing decreasing pay percentages for multiple surgeries performed during the same surgical session. When more than one surgical procedure is submitted for a patient on the same date of service, the 51 modifier is to be appended to the secondary code(s). Certain procedure codes are exempt from this process due to their status as "add-on" or "modifier 51 exempt" codes as defined in CPT.

Secondary Bilateral Surgical Procedures

Multiple modifiers may be appended to secondary surgical procedure codes when appropriate. Billing multiple surgical procedures and bilateral procedures during the same surgical session should follow Medicaid policy for each type of modifier.

Bilateral secondary procedures are submitted with modifiers 50/51 and at a minimum be reimbursed at 75% of the Medicaid allowable fee or the submitted charges, whichever is lowest.

Newborn Care and Discharge

The appropriate CPT codes for the initial care of the normal newborn may be paid when the service provided meets the criteria as defined by CPT. This service is limited to once per lifetime of the enrollee.

The CPT code for subsequent care of the normal newborn may be paid for each day care is rendered subsequent to the date of birth, other than the discharge date. The MCO shall cover up to three normal newborn subsequent care days.

NOTE: Refer to the *Hospital Services* section for hospital billing of newborn care.

Circumcisions

The MCO shall cover all medically necessary circumcisions.

Routine circumcision is an approved MCO value-added benefit.

Discharge Services

The MCO's policy for discharge services shall include the following:

- When the date of discharge is subsequent to the admission date, the provider shall submit claims for newborn hospital discharge services using the appropriate CPT code for hospital day management code.
- When newborns are admitted and discharged on the same date, the provider shall use the appropriate code for these services.

Newborn Screenings for Genetic Disorders

Newborn screening includes testing for certain specified conditions recommended by the American College of Medical Genetics. The MCO's policy shall include that La. R.S. 40:1081.1 and 40:1081.2 require hospitals with delivery units to screen all newborns before discharge regardless of the newborn's length of stay at the hospital. The Louisiana Administrative Code Title 48, Part V, Subpart 18, Chapter 63 provides the requirements related to newborn screenings.

NOTE: Refer to the *EPSDT Preventive Services Program* section for additional information on obtaining the results of newborn screenings for genetic disorders.

Neonatal/Pediatric Critical Care Billing

The MCO shall configure its claims processing systems, with regard to the billing of initial/subsequent neonatal and pediatric critical care and initial and continuing intensive care services, as follows:

- The claims billed with these codes will be configured to pay based on provider specialty.
- The provider specialties listed below will be configured to pay with these codes:
  - Neonatologist
  - Pediatric Intensivist
- Any other provider specialty that bills this set of codes will deny or pend. The MCO shall require the provider to follow the appropriate MCO reconsideration process.

Obstetrics

The MCO shall require that all prenatal outpatient visit evaluation and management (E&M) procedure codes be modified with TH. The TH modifier is not required for observation or inpatient hospital physician services.

Initial Prenatal Visit(s)

The MCO shall cover two initial prenatal visits per pregnancy (270 days). These two visits may not be performed by the same attending provider.

The MCO shall consider the enrollee a 'new patient' for each pregnancy whether or not the enrollee is a new or established patient to the provider/practice. The MCO shall require that the appropriate level E&M CPT procedure code be billed for the initial prenatal visit with the TH modifier. A pregnancy-related diagnosis code must also be used on the claim form as either the primary or secondary diagnosis.

Reimbursement for the initial prenatal visit, which must be modified with TH, shall include, but is not limited to, the following:

- Estimation of gestational age by ultrasound or firm last menstrual period. (If the ultrasound is performed during the initial visit, it may be billed separately. Also, see the ultrasound policy below.);
- Identification of patient at risk for complications including those with prior preterm birth;
- Health and nutrition counseling; and
- Routine dipstick urinalysis.

If the pregnancy is not verified, or if the pregnancy test is negative, the service may only be submitted with the appropriate level E&M without the TH modifier.

Follow-Up Prenatal Visits

The MCO shall require the provider to submit the appropriate level E&M CPT code from the range of procedure codes used for an established patient for the subsequent prenatal visit(s). The E&M CPT code for each of these visits must be modified with the TH modifier.

The reimbursement for this service shall include, but is not limited to:

- The obstetrical (OB) examination;
- Routine fetal monitoring (excluding fetal non-stress testing);
- Diagnosis and treatment of conditions both related and unrelated to the pregnancy; and
- Routine dipstick urinalysis.

Delivery Codes

The MCO's policy for coding deliveries shall include the following:

- The most appropriate "delivery only" CPT code shall be submitted. Delivery codes inclusive of the antepartum care and/or postpartum visit are not covered except in cases related to third party liability.
- Modifier -22 for unusual circumstances is to be used with the most appropriate CPT code for a vaginal or cesarean section delivery when the method of delivery is the same for all births.
- If the multiple gestation results in a cesarean section delivery and a vaginal delivery, the provider must use the most appropriate "delivery only" CPT code for the cesarean section delivery and also bill the most appropriate vaginal "delivery only" procedure code with modifier -51 appended.
- When a long-acting reversible contraceptive (LARC) is inserted immediately postpartum and prior to discharge, reimbursement shall be made separately for the insertion procedure and the LARC.

Global Maternity Care for Third Party Liability

Global maternity care includes pregnancy-related antepartum care, admission to labor and delivery, management of labor including fetal monitoring, delivery, and uncomplicated postpartum care. Other antepartum services are not considered part of global maternity services—they are reimbursed separately. An initial visit, confirming the pregnancy, is not a part of global maternity care services.

The MCO shall accept global maternity procedure codes for claims billed for secondary payment. Global maternity codes shall be recognized and considered for reimbursement only when billed to the MCO as secondary payer. The MCO shall deny claims billed to the MCO as primary payer. Refer to the Professional Services Fee Schedule for the global maternity procedure codes and rates.

The MCO shall calculate reimbursement based upon LDH TPL payment policy as defined in the Contract or this Manual.

LDH, or is contracted actuary, will consider maternity global codes in rate development. Global maternity codes shall only be payable when billed to the MCO as secondary payer; therefore, these codes will not be included in encounter kick payment logic.

The provider should bill prenatal, delivery, and/or postpartum services separately when the enrollee's coverage terminates prior to delivery.

Add-on codes for maternity-related anesthesia will not apply. The MCO should bypass add-on rates when modifiers 47 and 52 are reported.

Interest applies when a payable clean claim remains unpaid beyond the 30 day claims processing deadline. Refer to the Contract for detailed information.

Maternity claims where the enrollee's primary carrier does not cover maternity services should be billed to the MCO as primary payer. The MCO should accept global maternity procedure codes for claims billed only as secondary payer.

Postpartum Care Visit

The postpartum care CPT code (which is not modified with –TH) shall be reimbursed for the postpartum care visit when performed. Reimbursement is allowed for one postpartum visit per 270 days.

The reimbursement for the postpartum care visit includes, but is not limited to:

- Physical examination;
- Body mass index (BMI) assessment and blood pressure check;
- Routine dipstick urinalysis;
- Follow up plan for women with gestational diabetes;
- Family planning counseling;
- Breast feeding support including referral to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), if needed;
- Screening for postpartum depression and intimate partner violence; and
- Other counseling and or services associated with releasing a patient from obstetrical care.

Prenatal Laboratory and Ultrasound Services

Prenatal Lab Panels

The MCO shall cover the obstetric panel test as defined by CPT only once per pregnancy.

The MCO shall cover a complete urinalysis only once per pregnancy (270 days) per billing provider, or more when medically necessary, for example, to diagnose a disease or infection of the genitourinary tract.

Non-Invasive Prenatal Testing

Non-Invasive Prenatal Testing (NIPT) is a genetic test which uses maternal blood that contains cell-free fetal deoxyribonucleic acid (DNA) from the placenta. NIPT is completed during the pre-natal period of pregnancy to screen for the presence of some common fetal chromosomal abnormalities. Common types of chromosomal abnormalities (aneuploidies and microdeletions) in fetuses include:

- Trisomy 21 (Down syndrome);
- Trisomy 18 (Edwards syndrome); and

- ❖ Trisomy 13 (Patau syndrome).

The MCO shall cover NIPT when medically necessary and without the requirement of prior authorization.

NIPT is considered medically necessary once per pregnancy for pregnant women over the age of 35, and for women of all ages who meet one or more of the following high-risk criteria:

- ❖ Abnormal first trimester screen, quad screen or integrated screen;
- ❖ Abnormal fetal ultrasound scan indicating increased risk of aneuploidy;
- ❖ Prior family history of aneuploidy in first (1st) degree relative[10] for either parent;
- ❖ Previous history of pregnancy with aneuploidy; and
- ❖ Known Robertsonian translocation in either parent involving chromosomes 13 or 21.

The MCO shall not cover NIPT for women with multiple gestations.

Ultrasounds

A minimum of three obstetric ultrasounds shall be reimbursed per pregnancy (270 days) without the requirement of prior authorization or medical review when performed by providers other than maternal fetal medicine specialists:

- ❖ When an obstetric ultrasound is performed for an individual with multiple gestations, leading to more than one procedure code being submitted, this shall only be counted as one obstetric ultrasound; and
- ❖ Obstetric ultrasounds performed in inpatient hospital, emergency department, and labor and delivery triage settings are excluded from this count.

For maternal fetal medicine specialists, there shall be no prior authorization or medical review required for reimbursement of obstetric ultrasounds. In addition, reimbursement for CPT codes 76811 and 76812 is restricted to maternal fetal medicine specialists. In all cases, obstetric ultrasounds must be medically necessary to be eligible for reimbursement.

17-Alpha Hydroxyprogesterone Caproate

The MCO shall cover 17-alpha hydroxyprogesterone caproate (17P) without the requirement of prior authorization when substantiated by an appropriate diagnosis and all of the following criteria are met:

- ❖ Current pregnancy with a history of pre-term delivery before 37 weeks gestation;
- ❖ No symptoms of pre-term in the current pregnancy;
- ❖ Current singleton pregnancy; and
- ❖ Treatment initiation between 16 weeks 0 days and 23 weeks 6 days gestation.

Fetal Non-Stress Test

The MCO shall cover fetal non-stress tests when medically necessary as determined by meeting one of the following criteria:

- ❖ The pregnancy is post-date/post-maturity (after 41 weeks gestation);

[10] 1st degree relative is defined as a person's parent, child, or sibling.

- ❖ The treating provider suspects potential fetal problems in an otherwise normal pregnancy; or
- ❖ The pregnancy is high risk, including but not limited to diabetes mellitus, pre-eclampsia, eclampsia, multiple gestations, and previous intrauterine fetal death.

Fetal Biophysical Profile

The MCO shall cover fetal biophysical profiles when medically necessary, as determined by meeting at least two of the following criteria:

- ❖ Gestation period is at least 28 weeks
- ❖ Pregnancy must be high-risk, and if so, the diagnosis should reflect high risk
- ❖ Uteroplacental insufficiency must be suspected in a normal pregnancy

Tobacco Cessation Counseling During Pregnancy

The MCO shall cover tobacco cessation counseling for pregnant enrollees when provided by the enrollee's PCP or OB provider. Tobacco cessation counseling may be provided by other appropriate healthcare professionals upon referral from the enrollee's PCP or OB provider, but all care must be coordinated.

During the prenatal period through 60 days postpartum, the MCO shall cover up to four tobacco cessation counseling sessions per quit attempt, up to two quit attempts per calendar year, for a maximum of eight counseling sessions per calendar year. These limits may be exceeded if deemed medically necessary.

Minimum reimbursement for tobacco cessation counseling shall be based on the applicable current procedural terminology (CPT) code on the Professional Services Fee Schedule and must be supported by appropriate documentation. The MCO shall require the -TH modifier to be included on claims for tobacco cessation counseling within the prenatal period. The -TH modifier is not to be used for services in the postpartum period.

If tobacco cessation counseling is provided as a significant and separately identifiable service on the same day as an E&M visit and is supported by clinical documentation, a modifier to indicate a separate service may be used, when applicable.

Organ Transplants

The MCO shall cover medically necessary organ transplants when performed in a hospital that is a Medicare approved transplant center for that procedure.

Physician Administered Medication

The MCO shall cover medically necessary physician-administered medications that are reimbursable in Louisiana Medicaid. For those medications that are on the Louisiana Medicaid FFS fee schedules, the MCO shall also cover them in the medical benefit. The MCO may also elect to cover these medications in the pharmacy benefit. For those medications that are not on the Louisiana Medicaid FFS fee schedules, the MCO may cover them in either the medical benefit, the pharmacy benefit, or both.

Physician administered medication that are included on the PDL shall have the same preferred status and prior authorization criteria as the PDL, even when billed and paid as a medical benefit.

At a minimum, administration of the medication may be billed using the lowest level office visit (CPT procedure code 99211) if a higher-level evaluation and management visit has not been submitted for that date by the rendering provider. Any alternative reimbursement for medication administration must be equivalent to or greater than the reimbursement for CPT code 99211.

The MCO shall apply edits for physician-administered drugs, updated quarterly, based on the CMS NDC-HCPCS Crosswalk file.

Physician Assistants

Unless otherwise excluded by Louisiana Medicaid, the services rendered by physician assistants shall be determined by individual licensure, scope of practice, and supervising physician delegation. The supervising physician must be an enrolled Medicaid provider. Clinical practice guidelines and protocols shall be available for review upon request by authorized representatives of Louisiana Medicaid and contracted MCOs.

Immunizations, physician-administered drugs, long-acting reversible contraceptives, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) medical, vision, and hearing screens are reimbursed at a minimum of 100% of the physician fee on file. All other reimbursable procedures are reimbursed at a minimum of 80% of the physician fee on file.

Physician assistants must obtain an individual Medicaid provider number and, when the rendering provider, must bill under this provider number for services rendered.

Preventive Services for Adults

The MCO shall cover all United States Preventive Services Task Force Grade A and B preventive services for adults age 21 years and older without restrictions or prior authorization. In addition, the MCO shall cover one preventive medicine E&M service for adults aged 21 years and older per calendar year.

The MCO's policy for preventive medicine E&M services shall include the following:

- Providers are to use the appropriate Preventive Medicine Services "New Patient" or "Established Patient" Current Procedural Terminology (CPT) code based on the age of the enrollee when submitting claims for the services.
- The information gathered during the preventive medicine visit is to be forwarded to any requesting provider in order to communicate findings and prevent duplicative services.
- Preventive medicine E&M services are comprehensive in nature and should reflect age and gender specific services.
- The medical record documentation must include, but is not limited to:
    - Physical examination;
    - Medical and social history review;
    - Counseling/anticipatory guidance/risk factor reduction intervention; and
    - Screening test(s) and results.

In addition, the MCO shall cover one preventive gynecological examination per calendar year for enrollees aged 21 and over when performed by a primary care provider or gynecologist. This is to allow enrollees to receive both

the necessary primary care and gynecological components of their annual preventive screening visits. The visit must include:

- Examination;
- Sexually Transmitted Infection (STI) screening and counseling;
- Breast and pelvic examination;
- Pap smear, if appropriate; and
- Contraceptive methods and counseling, as age appropriate.

If an abnormality or pre-existing problem is encountered and treatment is significant enough to require additional work to perform the key components of a problem oriented E&M service on the same date of service by the provider performing the preventive medicine service visit, the MCO shall not cover any additional office visit of a higher level than CPT code 99212.

Radiology Services

The MCO shall cover inpatient and outpatient radiology services.

The MCO shall cover radiological services that may be required to treat an emergency or to provide surgical services for an excluded service, such as dental services.

The MCO shall not reimburse providers for the full service of radiology services that are not performed in the providers' own offices, including tests which are sent to other facilities for processing.

NOTE: Refer to the *Laboratory Services* and *Portable X-Ray Services* sections of this Manual for additional information.

Sinus Procedures

Balloon ostial dilation and functional endoscopic sinus surgery are considered medically necessary for the treatment of chronic rhinosinusitis when all of the following criteria are met:

- Uncomplicated chronic rhinosinusitis limited to the paranasal sinuses without the involvement of adjacent neurological, soft tissue, or bony structures that has persisted for at least 12 weeks with at least two of the following sinonasal symptoms:
  - Facial pain/pressure;
  - Hyposmia/anosmia;
  - Nasal obstruction;
  - Mucopurulent nasal discharge; and
- Sinonasal symptoms that are persistent after maximal medical therapy has been attempted, as defined by all of the following, either sequentially or overlapping:
  - Saline nasal irrigation for at least six weeks;
  - Nasal corticosteroids for at least six weeks;
  - Approved biologics, if applicable, for at least six weeks;
  - A complete course of antibiotic therapy when an acute bacterial infection is suspected;
  - Treatment of concomitant allergic rhinitis, if present; and
- Objective evidence of sinonasal inflammation as determined by one of the following:
  - Nasal endoscopy; or

- Computed tomography.

Balloon ostial dilation and functional endoscopic sinus surgery are not covered and not considered medically necessary in the following situations:

- Presence of sinonasal symptoms but no objective evidence of sinonasal disease by nasal endoscopy or computed tomography;
- For the treatment of obstructive sleep apnea and/or snoring when the above criteria are not met;
- For the treatment of headaches when the above criteria are not met; and
- For balloon ostial dilation only, when sinonasal polyps are present.

Skin Substitutes for Chronic Diabetic Lower Extremity Ulcers

The MCO shall cover skin substitutes and consider them to be medically necessary for the treatment of partial- and full-thickness diabetic lower extremity ulcers when the enrollee meets the criteria listed below.

Eligibility Criteria

The enrollee must meet all of the following criteria to be considered eligible:

- Presence of a lower extremity ulcer that:
  - Is at least 1.0 square centimeter (cm) in size;
  - Has persisted for at least four weeks;
  - Has not demonstrated measurable signs of healing, defined as a decrease in surface area and depth or a decreased amount of exudate and necrotic tissue, with comprehensive therapy including all of the following:
    - Application of dressings to maintain a moist wound environment;
    - Debridement of necrotic tissue, if present; and
    - Offloading of weight.
- A diagnosis of type 1 or type 2 diabetes mellitus;
- A glycated hemoglobin (HbA1c) level of ≤9% within the last 90 days or a documented plan to improve HbA1c to 9% or below as soon as possible;
- Evidence of adequate circulation to the affected extremity, as indicated by one or more of the following:
  - Ankle-brachial index (ABI) of at least 0.7;
  - Toe-brachial index (TBI) of at least 0.5;
  - Dorsum transcutaneous oxygen test (TcPO2) >=30 mm Hg; and/or
  - Triphasic or biphasic Doppler arterial waveforms at the ankle of the affected leg.
- No evidence of untreated wound infection or underlying bone infection; and
- Ulcer does not extend to tendon, muscle, joint capsule, or bone or exhibit exposed sinus tracts unless the product indication for use allows application to such ulcers.

The enrollee must not have any of the following:

- Active Charcot deformity or major structural abnormalities of the foot, when the ulcer is on the foot;
- Active and untreated autoimmune connective tissue disease;
- Known or suspected malignancy of the ulcer;
- Enrollee is receiving radiation therapy or chemotherapy; and

- ❖ Re-treatment of the same ulcer within one year.

Coverage Limitations

The following coverage limitations apply:

- ❖ Coverage is limited to a maximum of 10 treatments within a 12-week period;
- ❖ If there is no measurable decrease in surface area or depth after five applications, then further applications are not covered;
- ❖ For all ulcers, a comprehensive treatment plan must be documented, including at least all of the following:
  - o Offloading of weight;
  - o Smoking cessation counseling and/or medications, if applicable;
  - o Edema control;
  - o Improvement in diabetes control and nutritional status; and
  - o Identification and treatment of other comorbidities that may affect wound healing such as ongoing monitoring for infection.
- ❖ While providers may change products used for the diabetic lower extremity ulcers, simultaneous use of more than one product for the diabetic lower extremity ulcers is not covered; and
- ❖ Hyperbaric oxygen therapy is not covered when used at the same time as skin substitute treatment.

Prior Authorization

The MCO shall require prior authorization, and medical documentation submitted must demonstrate that the enrollee meets all of the aforementioned requirements. If there is no measurable decrease in surface area, or depth, after five applications, then the MCO shall not cover further applications, even when prior authorized.

Sterilizations

Coverage Requirements

In accordance with federal regulations, the MCO shall cover sterilizations if the following requirements are met:

- ❖ The individual is at least 21 years of age at the time the consent is obtained;
- ❖ The individual is not a mentally incompetent individual;
- ❖ The individual has voluntarily given informed consent in accordance with all federal requirements; and
- ❖ At least 30 days, but no more than 180 days, have passed between the date of the informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since an enrollee gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

The MCO shall not cover hysterectomies performed solely for the purpose of terminating reproductive capability (sterilization). Refer to the *Hysterectomies* section of this Manual for additional information.

Sterilization Consent Form Requirements

The MCO shall direct providers to use the current sterilization consent forms (HHS-687 available in English and HHS-687-1 available in Spanish) from the U.S. Department of Health and Human Services website [link].

The MCO shall require the consent form to be signed and dated by:

- The individual to be sterilized;
- The interpreter, if one was provided;
- The person who obtained the consent; and
- The physician performing the sterilization procedure.

NOTE: If the physician who performed the sterilization procedure is the one who obtained the consent, the physician must sign both statements.

The physician who obtains the consent must share the consent form with all providers involved in that enrollee's care (e.g., attending physician, hospital, anesthesiologist, and assistant surgeon).

Enrollees who undergo a covered hysterectomy must complete a hysterectomy consent form but are not required to complete a sterilization consent form. Refer to the *Hysterectomies* section of this Manual for additional information.

Consent Forms and Name Changes

For services requiring a sterilization consent form, the enrollee's name on the Medicaid file for the date of service must be the same as the name signed at the time of consent. If the enrollee's name is different, the provider must attach a letter from the provider's office from which the consent was obtained. The letter must be signed by the physician and must state the enrollee's name has changed and must include the enrollee's social security number and date of birth.

It is the MCO's responsibility to ensure that required documentation is maintained by the provider.

Correcting the Sterilization Consent Form

The informed consent must be obtained and documented prior to the performance of the sterilization.

Errors in the following sections can be corrected, but only by the person over whose signature they appear:

- "Consent to Sterilization";
- "Interpreter's Statement";
- "Statement of Person Obtaining Consent"; and
- "Physician's Statement".

If either the enrollee, the interpreter, or the person obtaining consent returns to the office to make a correction to his or her portion of the consent form, the medical record must reflect his or her presence in the office on the day of the correction.

To make an allowable correction to the form, the individual making the correction must line through the mistake once, write the corrected information above or to the side of the mistake, and initial and date the correction. Erasures, "write-overs", or use of correction fluid in making corrections are unacceptable.

Only the enrollee can correct the date to the right of their signature. The same applies to the interpreter, to the person obtaining consent, and to the doctor. The corrections of the enrollee, the interpreter, and the person obtaining consent must be made before the claim is submitted.

The date of the sterilization may be corrected either before or after submission by the doctor over whose signature it appears. However, the operative report must support the corrected date.

Reimbursement

Prior to reimbursement, the MCO shall ensure that the sterilization consent form is obtained. The MCO shall allow ancillary providers and hospitals to submit claims without the hard copy consent. The MCO shall reimburse these providers only if the provider performing the sterilization submitted a valid sterilization consent and was reimbursed for the procedure.

The MCO is responsible for maintaining required documentation and shall not shred documentation without prior approval by LDH.

Substitute Physician Billing

The MCO shall allow both the reciprocal billing arrangement and the locum tenens arrangement when providers utilize substitute physician services.

Reciprocal Billing Arrangement

A reciprocal billing arrangement occurs when a regular physician or group has a substitute physician provide covered services to a Medicaid enrollee on an occasional reciprocal basis. A physician can have reciprocal arrangements with more than one physician. The arrangements need not be in writing.

The enrollee's regular physician may submit the claim and receive reimbursement for covered services which the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis if:

- The regular physician is unavailable to provide the services.
- The substitute physician does not provide the services to Medicaid enrollees over a continuous period of longer than 60 days.

NOTE: A continuous period of covered services begins with the first day on which the substitute physician provides covered services to Medicaid enrollees of the regular physician, and ends with the last day on which the substitute physician provides these services to the enrollees before the regular physician returns to work. This period continues without interruption on days on which no covered services are provided on behalf of the regular physician. A new period of covered services can begin after the regular physician has returned to work. If the regular physician does not come back after the 60 days, the substitute physician must bill for the services under his or her own Medicaid provider number.

- The regular physician identifies the services as substitute physician services by entering the Healthcare Common Procedure Coding System (HCPCS) modifier - Q5 after the procedure code on the claim. By

entering the -Q5 modifier, the regular physician (or billing group) is certifying that the services billed are covered services furnished by the substitute physician for which the regular physician is entitled to submit Medicaid claims.

- ❖ The regular physician must keep on file a record of each service provided by the substitute physician and make the record available to Louisiana Medicaid or its representatives upon request.

This situation **does not apply** to the substitution arrangements among physicians in the same medical group where claims are submitted in the name of the group. On claims submitted by the group, the group physician who actually performed the service must be identified.

Locum Tenens Arrangement

A locum tenens arrangement occurs when a substitute physician is retained to take over a regular physician's professional practice for reasons such as illness, pregnancy, vacation, or continuing medical education. The substitute physician generally has no practice of his or her own. The regular physician usually pays the substitute physician a fixed amount per diem, with the substitute physician being an independent contractor rather than an employee.

The regular physician can submit a claim and receive reimbursement for covered services of a locum tenens physician who is not an employee of the regular physician if:

- ❖ The regular physician is unavailable to provide the services.
- ❖ The regular physician pays the locum tenens for his or her services on a per diem or similar fee-for-time basis.
- ❖ The substitute physician does not provide the services to Medicaid enrollees over a continuous period of longer than 60 days.

NOTE: A continuous period of covered services begins with the first day on which the substitute physician provides covered services to Medicaid enrollees of the regular physician, and ends with the last day on which the substitute physician provides these services to the enrollees before the regular physician returns to work. This period continues without interruption on days on which no covered services are provided on behalf of the regular physician. A new period of covered services can begin after the regular physician has returned to work. If the regular physician does not come back after the 60 days, a new 60-day period can begin with a different locum tenens doctor.

- ❖ The regular physician identifies the services as substitute physician services by entering HCPCS modifier -Q6 after the procedure code on the claim.
- ❖ The regular physician must keep on file a record of each service provided by the substitute physician and make the record available to Louisiana Medicaid, contracted MCOs, or its representatives upon request.

Telemedicine/Telehealth

Telemedicine/telehealth is the use of a telecommunications system to render healthcare services when a physician or other licensed practitioner and an enrollee are not in the same location.

The telecommunications system shall include, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the beneficiary at the originating site and the physician or other licensed practitioner at the distant site. The telecommunications system must be secure, ensure patient

confidentiality, and be compliant with the requirements of the Health Insurance Portability and Accountability Act.

Originating site means the location of the Medicaid enrollee at the time the services are provided. There is no restriction on the originating site and it can include, but is not limited to, a healthcare facility, school, or the enrollee's home.

Distant site means the site at which the physician or other licensed practitioner is located at the time the services are provided. When approved by LDH in accordance with the Contract, the distant site may include a provider or facility that is not physically located in this state in temporary or emergency situations (e.g., pandemics, natural disasters).

When otherwise covered, the MCO shall cover services located in the Telemedicine appendix of the CPT manual, or its successor, when provided by telemedicine/telehealth. In addition, the MCO shall cover other services provided by telemedicine/telehealth when indicated as covered via telemedicine/telehealth in Medicaid program policy. Physicians and other licensed practitioners must continue to adhere to all existing clinical policy for all services rendered. Providing services through telemedicine/telehealth does not remove or add any medical necessity requirements.

Reimbursement

The MCO shall reimburse the distant site provider for services provided via telemedicine/telehealth. Reimbursement for services provided by telemedicine/telehealth is at the same level as services provided in person.

The MCO shall require the provider to include in the enrollee's clinical record documentation that the service was provided through the use of telemedicine/telehealth.

The distant site provider must be enrolled as a Louisiana Medicaid provider to receive reimbursement for covered services rendered to Louisiana Medicaid enrollees.

Billing

Medicaid covered services provided using telemedicine must be identified on claims submissions form by appending the modifier "95" to the applicable procedure code and indicate Place of Service (POS) 02. The MCO shall deny claims that do not have both the correct POS and modifier present on the claim.

Therapy Services

The MCO shall cover speech therapy, physical therapy, and occupational therapy services to enrollees of any age and without restrictions to place of service.

Vagus Nerve Stimulators

The MCO shall cover implantation of the vagus nerve stimulator (VNS) when the treatment is considered medically necessary, the enrollee meets the published criteria, and the enrollee has a diagnosis of medically intractable epilepsy.

Criteria for Enrollee Selection

The following criteria shall be used to determine medical necessity of the VNS:

- Partial epilepsy confirmed and classified according to the International League Against Epilepsy (ILAE) classification. The enrollee may also have associated generalized seizures, such as tonic, tonic-clonic, or atonic. The VNS may have efficacy in primary generalized epilepsy as well;
- Age 12 years or older, although case by case consideration may be given to younger children who meet all other criteria and have sufficient body mass to support the implanted system;
- Seizures refractory to medical anti-epilepsy treatment, with adequately documented trials of appropriate standard and newer anti-epilepsy drugs or documentation of enrollee's inability to tolerate these medications;
- Enrollee has undergone surgical evaluation and is considered not to be an optimal candidate for epilepsy surgery;
- Enrollee is experiencing at least four to six identifiable partial onset seizures each month. Enrollee must have had a diagnosis of intractable epilepsy for at least two years. The two-year period may be waived if waiting would be seriously harmful to the enrollee to six identifiable partial onset seizures each month. Enrollee must have had a diagnosis of intractable epilepsy for at least two years. The two-year period may be waived if waiting would be seriously harmful to the enrollee;
- Enrollee must have undergone quality of life (QOL) measurements. The choice of instruments used for the QOL measurements must assess quantifiable measures of daily life in addition to the occurrence of seizures; and
- In the expert opinion of the treating physician, there must be reason to believe that QOL will improve as a result of implantation of the VNS. This improvement should occur in addition to the benefit of seizure frequency reduction. The treating physician must document this opinion clearly.

Exclusion Criteria

Regardless of the criteria for enrollee selection, the MCO shall not cover VNS implantation if the enrollee has one or more of the following criteria:

- Psychogenic seizures or other non-epileptic seizures;
- Insufficient body mass to support the implanted system;
- Systemic or localized infections that could infect the implanted system; or
- A progressive disorder contraindicated to VNS implantation (e.g., malignant brain neoplasm, Rasmussen's encephalitis, Landau-Kleffner syndrome and progressive metabolic and degenerative disorders).

Place of Service Restriction

The MCO shall restrict coverage of the surgery to implant the VNS to an outpatient hospital, unless medically contraindicated.

Coverage Requirements

Coverage for vagus nerve stimulation shall include, but is not limited to, the following:

- ❖ Vagus nerve stimulator;
- ❖ Implantation of VNS;
- ❖ Programming of the VNS; and
- ❖ Battery replacement.

In Lieu of Services

"In lieu of" services (ILOS) are alternative services or settings covered by the MCO as a substitute or alternative to services or settings covered under the Louisiana Medicaid State Plan. In accordance with 42 CFR § 438.3(e)(2), ILOS are medically appropriate and cost-effective substitute services that are offered voluntarily by the MCO. If offered, the MCO may not require enrollees to use any ILOS and the MCO reserves the right to cap or limit the number of enrollees receiving the ILOS at any time and for any reason. This section lists all approved ILOS that may be offered by the MCO.

Physical Health Services

Chiropractic Services for Adults Age 21 and Older

The purpose of this ILOS is to provide coverage of chiropractic care for enrollees age 21 and older. Chiropractic services to diagnose and treat neuromusculoskeletal conditions associated with the functional integrity of the spine are a medically appropriate and cost-effective substitute for services currently covered under the Louisiana Medicaid State Plan.

Provider Qualification

Qualified providers must be enrolled in Medicaid and meet the following requirements:

- ❖ Current, valid, and unrestricted Louisiana chiropractic license

Nothing herein shall be construed to require the MCO to execute an agreement with any qualified and willing provider. The MCO reserves the right to execute agreements with qualified providers only as needed to successfully provide services, if the MCO elects to offer this ILOS.

Covered Services

As part of this ILOS, chiropractic services for the purpose of diagnosing and treating neuromusculoskeletal conditions associated with the functional integrity of the spine are covered and considered medically necessary. The following requirements apply.

Evaluation and Management Services

The initial visit must include a treatment plan, including:

- ❖ Level of care (duration and frequency of visits);
- ❖ Treatment goals; and
- ❖ Measures to assess the effectiveness of treatment (qualitative and/or quantitative).

Follow-up visits must include information on the enrollee's progress in the treatment plan, along with the measures used to assess effectiveness.

The level of evaluation and management service shall be determined by using Current Procedural Terminology (CPT) guidelines.

X-Rays

X-rays may be used to assess the enrollee's condition. X-rays must be limited to the level(s) of suspected abnormality and the minimum number of views necessary to establish the diagnosis. Repeat X-rays are not considered medically necessary in the absence of a significant worsening of symptoms despite treatment, a change in the pattern of symptoms which may suggest an alternate diagnosis, or the development of new symptoms.

Spinal Manipulation

Spinal manipulation of up to five regions is covered and considered medically necessary when included in the documented treatment plan.

Other Treatments

Other treatments refer to chiropractic treatments other than spinal manipulation. On each date of service, a maximum of two other treatments are covered and must be tailored to the enrollee's condition and identified in the documented treatment plan.

- Mechanical traction
- Whirlpool therapy
- Ultrasound therapy
- Electrical stimulation
- Therapeutic exercises
- Neuromuscular reeducation
- Gait training
- Massage therapy
- Manual therapy
- Dry needling

Prior Authorization and Referral

Chiropractic ILOS are covered without the requirement of prior authorization for up to 18 treatment sessions annually. Additional treatment sessions may be reimbursed with authorization by the MCO. A treatment session is defined as all chiropractic services that occur on a single date of service. A referral from a primary care provider or any other provider is not required.

Reimbursement

Reimbursement for chiropractic services is only available to qualifying providers, as determined by the MCO.

Non-Compliance, Recoupment, and Sanctions

Use of all procedure codes must be in accordance with CPT guidance. Non-compliance with CPT guidance, failure to maintain adequate medical documentation to substantiate services rendered, or non-compliance with any of the provisions described in this document may result in recoupment and/or other sanctions as determined by the MCO.

Procedure Codes

The below table represents the procedure codes covered under this ILOS. The fees listed are calculated according to the methodology that would be employed by Medicaid FFS; however, the MCO has the discretion to execute agreements with providers for a different rate, when mutually agreeable. As specified above, a maximum of two other treatments, in addition to spinal manipulation, may be reimbursed per date of service.

Service Category	Code	Description	Reference Fee
Evaluation and management – new patient	99202	Office or other outpatient visit for the evaluation and management of a new patient	$42.77*
	99203		$62.18*
	99204		$96.56*
	99205		$122.19*
Evaluation and management – established patient	99212	Office or other outpatient visit for the evaluation and management of an established patient	$24.83*
	99213		$41.53*
	99214		$62.65*
	99215		$84.93*
Spinal X-rays	72020	Radiologic examination, spine, single view, specify level	$15.31*
	72040	Radiologic examination, spine, cervical; 2 or 3 views	$23.32*
	72050	Radiologic examination, spine, cervical; 4 or 5 views	$33.27*
	72052	Radiologic examination, spine, cervical; 6 or more views	$41.69*
	72070	Radiologic examination, spine, thoracic, 2 views	$22.60*
	72072	Radiologic examination, spine, thoracic, 3 views	$24.99*
	72074	Radiologic examination, spine, thoracic, minimum of 4 views	$29.46*
	72080	Radiologic examination, spine, thoracolumbar, 2 views	$23.29*
	72100	Radiologic examination, spine, lumbosacral; 2 or 3 views	$24.49*
	72110	Radiologic examination, spine, lumbosacral; minimum of 4 views	$34.22*
	72114	Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views.	$44.25*
	72120	Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views	$30.63*
	72220	Radiologic examination, sacrum and coccyx, minimum of 2 views	$19.65*
Spinal manipulation	98940	Spinal Manipulation 1-2 Regions	$16.87*
	98941	Spinal Manipulation 3-4 Regions	$23.40*
	98942	Spinal Manipulation 5 Regions	$38.13†
Other treatments‡	97012	Mechanical Traction	$10.76†
	97022	Whirlpool Therapy	$12.55†
	97035	Ultrasound Therapy	$10.40†
	97032	Electrical Stimulation	$11.01*
	97110	Therapeutic Exercises	$19.15*

	97112	Neuromuscular Reeducation	$19.59*
	97116	Gait Training	$16.72*
	97124	Massage Therapy	$15.20*
	97140	Manual Therapy	$17.72*
	20560	Needle insertion without injection 1-2	$19.10†
	20561	Needle insertion without injection 3 or more muscles	$27.39†

*From the Medicaid FFS fee schedule, as applicable to adults age 21 and older.
†Reference fee calculated using the methodology that would be employed by Medicaid FFS.
‡A maximum of two (2) other treatments, in addition to spinal manipulation, are covered per day of service.

Note: These fees are provided for reference purposes only, and the MCO may establish different fees in its agreements with providers.

Hospital-Based Care Coordination for Pregnant and Postpartum Individuals with Substance Use Disorder and Their Newborns

The purpose of this ILOS is to provide coverage of a comprehensive pregnancy medical home model of care to enrollees with substance use disorder (SUD) who are 18 years of age and older and pregnant or up to 12 months postpartum. The model includes care coordination, health promotion, individual and family support, and linkages to community/support services, behavioral, and physical health services. The model does not include coverage of physical and behavioral health services otherwise covered under the Louisiana Medicaid State Plan (e.g., outpatient OB care, SUD treatment services). In addition, this ILOS is not duplicative of MCO case management services.

This ILOS is a medically appropriate substitute for acute care utilization (e.g., emergency department visits, inpatient hospitalizations) due to inadequately-treated SUD during the pregnancy and postpartum periods. The benefit will not serve as a substitute for medically necessary physical and behavioral health services such as obstetrical care or SUD care. Rather, the ILOS will help to ensure that enrollees receive comprehensive physical and behavioral health care services that meet their needs, while avoiding preventable use of acute care.

Provider Qualifications

Eligible and qualified providers are hospitals that are enrolled in Medicaid and provide outpatient services with the following staffing specifications:

- At least one licensed mental health professional (LMHP), such as an LCSW or LPC with a current, valid, and unrestricted Louisiana license;
- Additional staff may include LMHPs, registered nurses, or advanced practice registered nurses with a current, valid, and unrestricted Louisiana license; and
- A staffing ratio of at least one LMHP or nurse for every 40 enrollees must be maintained.

Nothing herein shall be construed to require the MCO to execute an agreement with any qualified and willing provider. The MCO reserves the right to execute agreements with qualified providers only as needed to successfully provide services, if the MCO elects to offer this ILOS.

Covered Services

Services covered under the model are divided into three categories:

- ❖ Intake, assessment, and care plan development;
- ❖ Care coordination; and
- ❖ Outreach for disengaged enrollees.

Description	Services Provided
Intake, Assessment, Care Plan Development Time requirement: 2.5 hours total time (face-to-face and non-face-to-face time)	**Intake:** • Pregnancy confirmation; referral to OB if needed • Explanation of services • Obtaining informed consent for treatment • Obtaining detailed medical and social history • Create a mapping tool of contacts **Needs assessment through screenings:** • Initiate assessment of unmet care needs for physical (medical and nutritional), behavioral and psychosocial needs. At a minimum, these assessments are completed: o 5 P's Screening tool o DSM-5 Opioid Use Disorder Screening o NIDA Substance Use Screen o PHQ9 Depression Screening o GAD-7 Generalized Anxiety Disorder Screening o SDOH Health Leads Screening **Additional screenings may be added, to include:** o Columbia Suicide Severity Rating Scale o Perinatal Posttraumatic Stress Disorder Questionnaire o PCL-C PTSD Checklist – Civilian version o ACE Adverse Childhood Experience Questionnaire o MDQ Mood Disorder Questionnaire o HITS Intimate Partner Violence Screening **Plan of care development:** • Review assessments to identify care needs and discussing results with patient • Develop treatment plan of patient-centered goals, including referral to medication-assisted treatment (MAT) or SUD treatment • Assessing urgency of identified goals, prioritizing referrals based on needs, including housing referrals • Obtain plan of care developed by MCO case management, if applicable, for incorporation • Assessing Care Plan understanding through teach back to uncover any misunderstanding of the plan, the medical condition and objections. Adjusting plan and referrals as needed. • Providing warm handoff to referral sources.

	• Notification to MCO case managers of enrollment All activities shall be documented fully.
Care Coordination Time requirement: 10 hours per month of total time (face-to-face and non-face-to-face time). Non-face-to-face-time can include, but is not limited to: • Warm handoffs to other providers and community services • Contacting and communicating with physical and behavioral health providers • Following up on outcomes of referrals or visits • Updating the enrollee's care plan	**PRENATAL** **<u>General Activities</u>** • Confirmation of consent • Confirm and update birth plans • Confirm and update contact information • Assisting with benefit reinstatement, if indicated **<u>Care Coordination</u>** • Coordination of referrals identified from treatment plan, incorporating collaboration with the MCOs as needed to improve effectiveness and prevent duplication • Review and revision of care plan, as needed • Visit preparation, navigation, and follow up for key OB services • Coordination with MCO Case Manager to enhance care and prevent duplication • Multidisciplinary long-term postpartum follow-up includes referrals for medical, developmental, and social support for mother and infant **<u>Risk Assessment</u>** • Reviewing patient history from referral source (if applicable) and medical charts • Reassess physical, mental and social needs; identifying gaps • Providing assistance to close gaps for physical, mental and social needs • Review risks identified during assessment and addressing those risks • Assisting with development of peer support **<u>Alcohol/Substance Use Disorder Treatment</u>** • Interdisciplinary case conference with hospital care team during pregnancy, delivery and postpartum periods, including patient care plan. • Participation at SUD Treatment Case Conference, if indicated • Providing referral and/or education for Naloxone **<u>Health Education and Promotion</u>** • Orientation to labor and delivery process, including pain management plan and discussion of post-partum family planning, education on the importance of post-partum care • Provide individualized education on pregnancy, childbirth, parenting, physical well-being, lactation support and information on Neonatal Abstinence Support and related topics **DELIVERY CARE** • In-hospital, rooming in and assessment of neonatal opioid withdrawal syndrome (NOWS), if required staffing and space are available • Lactation support and follow up education • Assessing baby safety needs

	• Navigating and educating mother for potential NICU admission, as needed • Assessment of care transition to home **POSTPARTUM CARE** **<u>Care Coordination</u>** • Identifying/connecting patient with peer support • Provide referrals for medical, developmental and social support, (WIC, Healthy Start, Early Steps) • Follow meconium drug screening and report to DCFS, if appropriate • Visit preparation and follow up for pediatric visits • Assist with/make referral to pediatrician • Identifying NOWS and neonatal abstinence syndrome (NAS) support by care partners **<u>Health Education and Promotion</u>** • Discussion of postpartum needs, including importance of postpartum care, red flag warnings for postpartum hygiene, signs and symptoms of illness for mother, sleep and nutritional needs. • Discussion of red flag warnings for signs and symptoms of newborn illness, feeding and lactation support, care of baby's skin, mouth, umbilical cord and circumcision **<u>Risk Assessment</u>** • Reassessment for depression and anxiety screening with on-site treatment or referral as indicated • Provide education and advocacy for DCFS reporting and the justice system • Documentation of activities and progress across all categories of care coordination activities
Outreach for Disengaged Enrollees Time requirement: 8 hours per month total time (face-to-face and non-face-to-face time).	• Maintaining and reviewing call log for potential disengagement • Medical record review for missed physician or diagnostic appointments • Checking with SUD treatment providers for missed appointments • Contact attempts by preferred contact method at least three times on different days and different times of day • Escalating contact tracking to friends, family, employer, judicial, social services, etc., from contact mapping • Documentation of efforts made for outreach attempts

Prior Authorization and Referral

Services under this ILOS are covered without the requirement of prior authorization or referral. The MCO may make referrals to providers of this service at its discretion.

Reimbursement

Reimbursement for these services is only available to qualifying providers, as determined by the MCO. Providers are advised to contact the MCOs for specific additional guidance prior to rendering services.

Non-Compliance, Recoupment, and Sanctions

Use of all procedure codes must be in accordance with this terms and conditions described in this document. Failure to maintain adequate medical documentation to substantiate services rendered or non-compliance with any of the provisions described in this document may result in recoupment and/or other sanctions as determined by the MCO.

Procedure Codes

The below table represents the procedure codes covered under this ILOS. The fees listed are estimated by Medicaid's actuarial consultant based on a time study; however, the MCO has the discretion to execute agreements with provider for a different rate, when mutually agreeable.

Service	Service Code	Maximum Units per Pregnancy and Postpartum Period	Estimated Fee
Intake, Assessment, Care Plan Development	H0002	1	$77.60/unit
Care Coordination	H0006	20	$221.06/unit (1 unit = 1 month)
Outreach for Disengaged Enrollees	H0023	4	$133.63/unit (1 unit = 1 month)

The primary diagnosis code on the claim should reflect the primary substance use disorder experienced by the enrollee.

Behavioral Health Services

MCOs must notify LDH of their intent to offer any of the authorized ILOS within this section and provide their proposed service definitions for prior approval.

23-Hour Observation Bed Services for Adults Age 21 and Older

This ILOS is an inpatient hospital-based intervention designed to allow for the opportunity to hold and assess an enrollee without admitting them.

Behavioral Health Crisis Care

This ILOS is an initial or emergent psychiatric crisis response intended to provide relief, resolution and intervention through crisis supports and services during the first phase of a crisis for adults in an outpatient setting.

NOTE: The authorization for this ILOS will be terminated when comparable services are implemented in the Louisiana Medicaid State Plan.

Crisis Stabilization Units for Adults Age 21 and Older

The purpose of this ILOS is to provide treatment via the least restrictive level of care, allowing an alternative to inpatient hospitalization.

NOTE: The authorization for this ILOS will be terminated when comparable services are implemented in the Louisiana Medicaid State Plan.

Freestanding Psychiatric Hospitals for Adults Ages 21-64

The purpose of this ILOS is to assist adult enrollees with significant behavioral health challenges. This population is often treated in more expensive general hospital psychiatric units, which creates access issues as beds in this setting are limited. Individuals often remain in emergency departments while waiting for available beds, thereby increasing costs to the healthcare system as they utilize those medical resources while awaiting beds in general hospitals. Use of freestanding psychiatric units reduces emergency department consumption, increases psychiatric bed capacity, and provides a less costly alternative to general hospital beds.

Injection Services Provided by Licensed Nurses to Adults Age 21 and Older

Many enrollees are unable or unwilling to take oral psychotropics, or their mental status indicates a need for injectable medication to ensure compliance and stability. Embedded in the cost of many E&M coded visits is the cost of providing injectable medications. Allowing licensed nurses instead of physicians to perform this service delivery results in the most cost efficient and least costly service delivery, and helps to ensure compliance. The goals are reducing subsequent office visits and reducing hospitalizations due to lack of compliance.

Mental Health Intensive Outpatient Programs

The purpose of this ILOS is to provide enrollees treatment via the least restrictive level of care, allowing an alternative to inpatient hospitalization or Assertive Community Treatment and providing a step-down option from inpatient hospitalization for enrollees at high risk for readmission.

Mobile Crisis Response

This ILOS is an initial or emergent crisis response intended to provide relief, resolution, and intervention through crisis supports and services during the first phase of a crisis in the community.

NOTE: The authorization for this ILOS will be terminated when comparable services are implemented in the Louisiana Medicaid State Plan.

Population Health Management Programs

Mindoula Clinical Services' Population Health Management Program (PHMP) is a precision solution that targets, engages, and serves enrollees with SMI, SUD, and/or Sickle Cell Disease (SCD) and other comorbid medical

conditions through team-based, tech-enabled, care extension services. This focused approach includes (1) identification of enrollees for the PHMP using proprietary algorithms and enrollee archetype data, (2) outreach and enrollment of enrollees using an intake process specific to SMI, SUD, and SCD populations, and (3) provision of tech-enabled programmatic interventions that include content and methods tailored to reducing total costs of care by addressing behavioral, medical, and social needs specific to SMI, SUD, and SCD populations.

These interventions are designed to enhance participants' skills, strategies, and supports, which in turn help to prevent and reduce unnecessary and avoidable medical costs associated with SMI, SUD, SCD, and other comorbid medical conditions, during the program and even after its completion.

PART 5: PROVIDER CLAIMS & REIMBURSEMENT

The MCO shall administer an effective, accurate and efficient claims processing system that adjudicates provider claims for covered services that are fulfilled within the timeframes specified in the Contract and the Manual.

LDH is responsible for setting and defining minimum provider rates for Medicaid covered services. The MCO shall reimburse providers no less than the published Medicaid FFS rate or that is contained on the weekly procedure file sent to the MCO by the fiscal intermediary in effect on the date of service unless mutually agreed to by both the MCO and the provider. Nothing herein shall restrict the MCO from reimbursing at a higher rate than would be reimbursed by Medicaid FFS.

EXCEPTIONS TO CLAIMS TIMELY FILING GUIDELINES

MCOs must comply with the following exceptions to the 365-day timely filing guidelines:

- **Administrative Error:** This is where the failure to meet the filing deadline is caused by error or misrepresentation of the MCO, its subcontractor, or LDH. In these cases, the MCO shall extend the timely filing through the last day of the sixth month following the month in which the enrollee, provider, or supplier received notice from the MCO that an error or misrepresentation was corrected.
- **Retroactive Medicaid entitlement or retroactive MCO enrollment:** This is where a beneficiary receives notification of Medicaid entitlement and/or MCO enrollment retroactive to or before the date the service was furnished. In these cases the MCO shall extend timely filing to 365 calendar days from the date of service or 180 calendar days from the enrollee's linkage add date in the enrollee's 834 eligibility file, whichever is later.

PAYMENT RECOUPMENTS

The MCO may recoup provider payments for a variety of reasons, including but not limited to the following:

- Retroactive enrollment or disenrollment due to Medicaid or Medicare eligibility changes;
- Discovery of improper payments through either of the following reviews:
  - Automated review (i.e., analysis of paid claims) up to one year from the date of payment;
  - Complex review (i.e., requires review of medical, financial, and/or other records) up to five years from date of service; or
- Third party liability.

The MCO shall not recoup payments simply on the basis of an encounter being denied. The MCO may submit inquiries about encounter denials using the MMIS Inquiry Form as outlined in the **MCO System Companion Guide**.

The MCO should refer to the *Eligibility and Enrollment* and *Third Party Liability* sections of this Manual as well as the Contract for additional requirements, including provider notification requirements.

PART 6: ENCOUNTERS

The MCO shall submit encounter data according to specifications, including data elements and reporting requirements, outlined in the **MCO System Companion Guide**

The MCO shall submit paid, denied, adjusted, and voided claims with the appropriate identifiers established in the **MCO System Companion Guide** to indicate these claims as encounters.

The MCO should refer to the **MCO System Companion Guide** for a list of encounter edit codes.

SKILLED NURSING FACILITIES ENCOUNTER CLAIMS

This guidance is regarding the bill type to capture the reimbursement of skilled nursing facilities as an in lieu of service.

The fiscal intermediary is currently rejecting encounters for skilled nursing facilities when MCOs use bill type 21x. Therefore, LDH is authorizing MCOs to amend the bill type when submitting the encounters for skilled nursing facilities that are medically appropriate and a cost effective alternative to an inpatient hospital stay, to bill type 11x (instead of bill type 21x). By taking this action, these encounters will be captured as inpatient skilled nursing facility encounter claims.

PART 7: PROVIDER SERVICES

The MCO must engage with its network providers to enhance service delivery, improve provider and enrollee satisfaction, promote data sharing and value-based payment strategies, and enable regular provider participation in clinical policy development and provider operations. This section provides additional information on ways in which the MCO interacts and supports its providers to ensure that providers receive timely reimbursement and appropriate support over the course of the Contract.

PROVIDER ISSUE RESOLUTION

The MCO shall provide options to providers for pursuing resolution of issues. Providers should first seek resolution with the MCO directly prior to engaging LDH or other third parties, except when the MCO has demonstrated a pattern of the same issue reoccurring.

Claim Reconsideration, Appeal, and Arbitration

The MCO shall maintain, in accordance with Informational Bulletin 19-3 or as otherwise approved by LDH, claim dispute procedures for providers who wish to file formal claim reconsideration requests and claim appeals. Procedures should include submission instructions and timelines.

In any instance where a provider claim is denied, the consent of the enrollee who received services shall not be required in order for the provider to dispute the denial of the claim. The provider may pursue a claim dispute on the basis of nonpayment for rendered services under the terms and conditions outlined in their provider contract with the MCO or as otherwise provided by Louisiana law. The enrollee who received the services shall not be required to sign an authorized representative form, or provide other forms of written consent, for the provider to dispute the denied claim for payment. For each denied claim, providers must be notified of the amount and reason for the denial.

In any case where a provider is required to obtain a service authorization on a concurrent or post-service basis, the consent of the enrollee who received the service shall not be required in order for the provider to dispute the denied authorization for service.

Providers who have completed the MCO dispute process and remain dissatisfied with the MCO's determination may submit a written request for arbitration. The request should include decisions from all claim reconsideration requests and claim appeals.

Providers may escalate claim disputes to LDH via e-mail at ProviderRelations@la.gov.

NOTE: Per La. R.S. 46:460.81, an adverse determination involved in litigation or arbitration or not associated with a Medicaid enrollee shall not be eligible for independent review.

Independent Review

Independent review is another option for resolution of claim disputes. The Independent Review process may be initiated after claim denial.

NOTE: Per La. R.S. 46:460.81, an adverse determination involved in litigation or arbitration or not associated with a Medicaid enrollee shall not be eligible for independent review.

- The Independent Review process was established by La. R.S. 46:460.81, *et seq*. to resolve claims disputes when a provider believes an MCO has partially or totally denied claims incorrectly. An MCO's failure to send a provider a remittance advice or other written or electronic notice either partially or totally denying a claim within 60 days of the MCO's receipt of the claim is considered a claims denial.
- Independent Review is a two-step process which may be initiated by submitting an Independent Review Reconsideration Request Form to the MCO within 180 calendar days of the Remittance Advice paid, denial, or recoupment date.
- If a provider remains dissatisfied with the outcome of an Independent Review Reconsideration Request, the provider may submit an Independent Review Request Form to LDH within 60 calendar days of the MCO's decision.
- There is a $750 fee associated with an independent review request. If the independent reviewer decides in favor of the provider, the MCO is responsible for paying the fee. Conversely, if the independent reviewer finds in favor of the MCO, the provider is responsible for paying the fee.
- SIU post-payment reviews are not considered claims denials or underpayment disputes, therefore, SIU findings are exempt from the Independent Review Process.
- Additional detailed information and copies of above referenced forms are available on the LDH website [link].

Provider Issue Escalation and Resolution

A provider may desire to escalate an issue to the attention of the MCO's executive team. This may apply to claim or non-claim related issues.

The MCO is required to maintain a Provider Complaint System for in-network and out-of-network providers to dispute the MCO's policies, procedures, or administrative functions. This system should include contacts for filing a formal complaint and then for escalating to management and executive levels. Providers should first seek resolution with the MCO, using these contacts. If a provider is unable to reach satisfactory resolution or get a timely response through the MCO escalation process, direct contact with LDH via ProviderRelations@la.gov is also an option.

If the MCO, LDH, or its subcontractors discover errors made by the MCO when a claim was adjudicated, the MCO shall make corrections and reprocess the claim within 30 calendar days of discovery, or if circumstances exist that prevent the MCO from meeting this time frame, a specified date shall be approved by LDH. The MCO shall automatically recycle all impacted claims for all providers and shall not require the provider to resubmit the impacted claims.

ENROLLEE REASSIGNMENT POLICY

The MCO shall have an enrollee reassignment policy that complies with the following core elements to ensure that enrollees are assigned to the most appropriate PCP. The policy, and any revisions, shall be reviewed and approved by LDH at least 30 calendar days prior to implementation.

The following core elements shall apply to all in-network PCPs, all enrollees who have been assigned to the current PCP for at least 90 days, and enrollees who have no seen the assigned PCP within the prior 12 months.

The MCO should refer to the Contract for requirements related to the enrollee's initial assignment.

Analysis

The MCO shall perform claims analysis on a quarterly basis and based on the previous 12 months (at minimum) of claims history, including wellness visits and sick visits.

Reassignment

An enrollee will only be eligible for reassignment if they have visited an unassigned PCP at least once within the previous 12 months.

- If the enrollee has seen an unassigned PCP within the same tax ID number (TIN) as the assigned PCP, the enrollee will not be reassigned.
- If an enrollee has not seen the assigned PCP and has seen multiple unassigned PCPs, the enrollee will be assigned to the PCP with the most visits.
    - If the enrollee has the same number of visits with multiple unassigned PCPs, the enrollee will be assigned to the most recently visited PCP.

Enrollees who have not seen the assigned PCP or any other PCP will not be reassigned.

If the enrollee has an established relationship, defined by at least one claim within the previous 12 months, with an unassigned PCP, the MCO will reassign that enrollee appropriately, even if the unassigned PCP's panel shows that it is closed. The enrollee-PCP relationship takes priority over a closed panel.

All reassignments shall be prospective.

Provider Notification

MCOs must publish the results of the claims analysis to their provider portals on the 15th calendar day of the second month of each quarter. If the due date falls on a weekend or a State-recognized holiday, the results shall be published on the next business day.

The results shall identify all enrollees eligible for reassignment from the PCP along with enrollees eligible for reassignment to the PCP. Enrollees identified as eligible for reassignment to the PCP shall be shared as informational only considering this data is subject to change via the dispute protocol below.

The results of the analysis shall be published in a format that is able to be downloaded/exported into Excel. The PCP is allowed 15 business days to review before any enrollees are reassigned.

MCOs must also include a protocol for provider disputes with the results from the claim analysis. To dispute the reassignment of the enrollee(s) from the PCP, the provider must provide documentation (e.g., medical record, proof of billed claim, etc. for at least one date of service) that they have seen the enrollee(s) during the previous 12 months.

MCOs must incorporate a flag for providers to identify new enrollees on their rosters/panels easily and a flag to indicate if the enrollee was auto-assigned or not. This flag is for all enrollees, not just reassigned enrollees.

Enrollee Notification

MCOs must incorporate the process for notifying the affected enrollees within the policy.

LDH Notification

In accordance with the standard reporting deadlines established in the Contract, MCOs shall report the following to LDH on a quarterly basis:

- Number of PCPs included in the analysis.
- Number of PCPs with at least one enrollee reassigned from their panel.
- Number of PCPs with at least one enrollee reassigned to their panel.
- The name of any PCP that had no changes to their panel from the reassignment analysis.

PART 8: ENROLLEE SERVICES

This section provides information related to services provided by the MCO to its enrollees. Additional information may be found in the **Marketing and Member Education Companion Guide**.

AUTHORIZED REPRESENTATIVES OR LEGAL REPRESENTATIVES

Medicaid enrollees may appoint an authorized representative (AR) to accompany, assist, and represent them in matters related to their Medicaid coverage. In addition, parents are generally authorized to speak on their minor child's behalf regarding the child's Medicaid without an executed AR form, as long as the parent has been verified to hold such parental authority. Also, an enrollee may have a legal representative who is designated by operation of law or by the action of a court. For example, an unemancipated minor child will have someone with parental authority to act on his or her behalf; usually it will be the parent(s), although in some cases it may be another person (e.g., legal guardian/curator) or entity who has been appointed by a court (e.g., DCFS when it has legal custody of a child in foster care).

The case record maintained by LDH is the definitive source of the identity of an enrollee's AR or legal representative. The MCO may contact LDH to obtain verification of who is authorized to speak and act on behalf of the enrollee.

If the MCO needs assistance determining whether a caller is an AR for an enrollee, the MCO should contact the Medicaid Customer Service Unit (CSU) for a verbal verification. The MCO may conduct the verification through a three-way call with the AR if preferred. MCOs may call the CSU hotline at 888-342-6207 from 8:00 a.m. to 4:30 p.m. to reach an LDH representative.

The MCO should accept this verification as the source of truth in confirming or denying who is authorized to speak on behalf of the enrollee. The MCO should not require any additional documents from Medicaid or the enrollee.

In some cases, an MCO may learn of an actual or potential change in an enrollee's AR or legal representative before Medicaid does. If that happens, the MCO should be proactive in educating the enrollee/caller to report changes to Louisiana Medicaid within 10 days and provide direction on contacting Louisiana Medicaid for assistance.

Nothing in this guidance should be interpreted as creating a barrier to access to treatment for enrollees who are unable to speak for themselves. If a minor child is brought to a network provider by an adult who does not have verified parental authority or an AR designation in the child's record, a reasonable effort should be made to contact the AR, or the person with verified parental authority over the minor child, to obtain the appropriate consent for treatment; however, even if that attempt is unsuccessful, it is still legally possible for the provider to furnish necessary treatment to the child, particularly in emergency situations.

This guidance does not affect the ability of a duly designated AR to sign an authorization permitting the disclosure of an enrollee's protected health information to a third person. Medicaid does not seek to dictate the precise authorization forms to be used by MCOs and their providers, other than to require that they be HIPAA compliant. Generally, Medicaid will honor any valid, HIPAA compliant authorization that permits it to disclose the requested

information, but will no longer honor the HIPAA authorization when the person who signed it ceases to be the enrollee's AR or is otherwise unauthorized to speak and act on behalf of the enrollee. The MCO should follow the same policy.

A disclosure authorization of the type discussed in the preceding paragraph is not the same thing as a written consent for a provider to file a grievance or appeal or to request a state fair hearing on behalf of an enrollee. If an enrollee, an enrollee's AR, or an enrollee's verified legal representative wishes to permit a provider to take such action on the enrollee's behalf, a disclosure authorization by itself will not be sufficient for that purpose.

ENROLLEE RIGHTS AND RESPONSIBILITIES

Each enrollee is guaranteed the following rights:

- To be treated with respect and with due consideration for his or her dignity and privacy.
- To participate in decisions regarding his or her health care, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the federal regulations on the use of restraints and seclusion.
- To be able to request and receive a copy of his or her medical records (one copy free of charge) and request that they be amended or corrected.
- To receive healthcare services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition. To receive all information (e.g., enrollment notices, informational materials, instructional materials, available treatment options and alternatives) in a manner and format that may be easily understood as defined in the Contract between LDH and the MCO.
- To receive assistance from both LDH and the enrollment broker in understanding the requirements and benefits of the MCO.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services.
- To receive information on the MCO's services, to include, but not limited to:
    - Benefits covered;
    - Procedures for obtaining benefits, including any authorization requirements;
    - Any cost sharing requirements;
    - Service area;
    - Names, locations, telephone numbers of and non-English language spoken by current contracted providers, including at a minimum, primary care dentist, specialists, and hospitals ;
    - Any restrictions on enrollee's freedom of choice among network providers;
    - Providers not accepting new patients; and
    - Benefits not offered by the MCO but available to enrollees and how to obtain those benefits, including how transportation is provided.
- To receive a complete description of disenrollment rights at least annually.
- To receive notice of any significant changes in core benefits and services at least 30 days before the intended effective date of the change.

- To receive information on grievance, appeal, and state fair hearing procedures.
- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
    - What constitutes an emergency medical condition, emergency services, and post-stabilization services;
    - That emergency services do not require prior authorization;
    - The process and procedures for obtaining emergency services;
    - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the Contract;
    - Enrollee's right to use any hospital or other setting for emergency care; and
    - Post-stabilization care services rules as detailed in 42 C.F.R. §422.113(c).
- To receive the MCO's policy on referrals for specialty care and other benefits not provided by the enrollee's PCP.
- To have his or her privacy protected in accordance with the privacy requirements in 45 C.F.R. Part 160 and Part 164, Subparts A and E, to the extent that they are applicable.
- To exercise these rights without adversely affecting the way the MCO, its providers or LDH treat the enrollee.

GRIEVANCES, APPEALS, AND STATE FAIR HEARINGS

Continuation of Benefits

An enrollee is only entitled to a continuation of benefits pending resolution of an appeal or state fair hearing when a previously authorized benefit is terminated, suspended, or reduced prior to the expiration of the current service authorization.

Expiration of an approved number of visits does not constitute a termination for purposes of notice and continuation of benefits. The cessation of services because the authorization expired is not cause for a continuation of benefits, since the enrollee had no right to expect the services to continue beyond the "previously authorized" quantity, period, or duration.

When a prescription, including refills, runs out and the enrollee requests another prescription, this is a new request, not a termination of benefits. In these circumstances, the MCO is not required to send a notice or continue benefits pending the outcome of an appeal or state fair hearing. If the enrollee requests a reauthorization that the MCO denied, the MCO shall treat this request as a new request for service authorization and provide notice of the denial or limitation.

RETURNED MAIL PROCEDURES

When the MCO receives returned enrollee-related mail, the MCO should first identify whether a forwarding address has been received.

If a forwarding address is received, the MCO shall:

- For out-of-state addresses, follow procedures in place for reporting an enrollee disenrollment request to the enrollment broker.

- ❖ For in-state addresses, attempt to contact (including, but not limited to, by phone, mail, e-mail, text) the enrollee to verify that the newly received address is correct.

If no forwarding address is received, the MCO shall attempt to contact the enrollee as described above.

PART 9: THIRD PARTY LIABILITY

Pursuant to federal and state law, the Medicaid program by law is intended to be the payer of last resort. This means all other available third party liability (TPL) resources must meet their legal obligation to pay claims before the MCO pays for the care of an individual eligible for Medicaid.

The following third parties must be billed prior to billing Medicaid. This list is not exhaustive.

- Health insurance:
  - Policies and indemnity policies that make payment when a medical service is provided and that restrict payment to the period of hospital confinement.
  - Policies that pay income supplements for lost income due to disability or policies that make a payment for a disability, such as weekly disability policy, are not included;
- Major medical, drug, visions care and other supplements to basic health insurance contracts;
- TRICARE-provides coverage for off base medical services to dependents of uniformed service personnel, active or retired;
- Veteran Administration (CHAMP-VA) provides coverage for medical services to dependents of living and deceased disabled veterans;
- Railroad Retirement;
- Automobile medical insurance;
- Worker's compensation;
- Liability insurance-includes automobile insurance and other public liability policies, such as home accident insurance, etc.; and
- Family health insurance carried by an absent parent.

When an enrollee has other insurance, the enrollee must follow any and all requirements of that insurance since it is primary. If the enrollee does not follow private insurance rules and regulations, the MCO will not be responsible for considering reimbursement of those services. Thus, the enrollee will be responsible for the payment of the services.

Providers must determine, prior to providing services, to which commercial plan the enrollee belongs and if the provider of service is a part of the network of that particular plan. Enrollees must be informed prior to the service that they will be responsible for payment if they choose to obtain services from an out-of-network provider and their commercial plan does not offer out-of-network benefits.

When an enrollee has other insurance, with the exception of specialized behavioral health services, the provider shall first seek authorization from the primary payer; if authorized by the primary payer, the provider shall bill the MCO as secondary payer. If not authorized by the primary payer, the provider may seek authorization from the MCO for evaluation of medical necessity.

The MCO shall process these claims as they were processed by the primary payer. The payment information indicated on the primary payer's EOB will be used to process the claim. Additionally, Medicaid TPL payments will be calculated differently for enrollees enrolled through the Louisiana Health Insurance Premium Payment Program (LaHIPP). Refer to the *LaHIPP* section for LaHIPP TPL calculation.

COST AVOIDANCE

Except for "pay and chase" claims identified in this section, the MCO shall cost-avoid a claim if it establishes the probable existence of another health insurance at the time the claim is filed. The MCO shall deny the claim for coordination of benefits (COB) and return it back to the provider noting the third party the MCO believes to be legally responsible for payment.

If a balance remains after the provider bills the liable third party or the claim is denied payment for a substantive reason, the provider may submit a claim to the MCO for payment of the balance up to the maximum allowable Medicaid reimbursement amount.

PAY AND CHASE VS. WAIT AND SEE

The "pay and chase" method occurs when payment is made by the MCO for submitted claims even if a third party is likely liable, and the MCO then seeks to recoup payments from the liable third party.

The MCO shall reimburse no less than the full amount allowed under Medicaid's payment schedule, and then seek recovery of payment from the third party within 60 days after the end of the month in which payment is made (or within 60 days after the end of the month the MCO learns of the existence of a liable third party) when:

- The service is Preventive Pediatric Care (PPC), including Early and Preventive Screening, Diagnostic, and Treatment (EPSDT), EPSDT referral and when well-baby procedure codes 99460, 99462, and 99238 are billed with diagnosis codes Z38 through Z38.8.

  NOTE: The MCO shall use the pay and chase method of payment for preventive pediatric services for individuals under the age of 21 with other Health Insurance when the pediatric preventive diagnosis code is reported in the primary position of the claim. Hospitals are not included and must continue to file claims with the health insurance carriers. Primary preventive diagnoses are confined to those listed on www.lamedicaid.com [link]. EPSDT referral is indicated as "Y" in block 24H of the CMS-1500 claim form or "A1" as a condition code on the UB-04 (form locators 18-28).

Section 53102(a)(1) of the Bipartisan Budget Act of 2018 removes prenatal care from pay and chase services.

The MCO must "wait and see" on claims for a service that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV D agency. "Wait and see" is defined as payment of a claim only after the documentation is submitted to the MCO demonstrating that 100 days have elapsed since the provider billed the responsible third party and remains to be paid. The MCO shall identify third party liability enforced by the State Title IV-D agency by initiator code 02 in TPL files transmitted by LDH's fiscal intermediary. Refer to the **MCO System Companion Guide** for the TPL file layout and initiator codes.

The provider can only bill Medicaid for the balance not paid for by the liable third party and payment can only be made for up to the Medicaid allowable amount.

MANAGING THIRD PARTY LIABILITY FILE EXCHANGES AND ENROLLEE UPDATES

The LDH TPL contractor discovers, verifies, and adds/updates insurance coverage leads for all Medicaid enrollees. The TPL contractor completes all insurance coverage lead update requests from MCOs, LDH, providers, and enrollees within four business hours for urgent requests, and within five business days for non-urgent requests. Additionally, the TPL contractor performs a monthly data match against all Medicaid enrollees and deliver verified insurance data to the fiscal intermediary within 30 days of the match.

LDH defines urgent TPL requests as the inability of an enrollee to have a prescription filled or the inability of an enrollee to access immediate care because of incorrect third party insurance coverage.

The LDH TPL contractor is the sole source for electronic TPL resource file add/updates. Responsibilities for each entity are as follows[11]:

- The TPL contractor sends daily TPL file exchanges to the fiscal intermediary.
- The fiscal intermediary sends daily incremental TPL files to the MCOs every business day.
- Every Monday, the fiscal intermediary sends weekly TPL full reconciliation files to the MCO.
- The MCOs submit daily general TPL add/update requests to the TPL contractor via e-mail or fax on the Daily General MCO TPL Request Form.
    - E-mail: latpr@hms.com
    - Fax: 1-877-204-1325
    - Phone: 1-877-204-1324
    - Hours of Operation: Monday - Friday, 8 a.m. - 5 p.m. Louisiana state holidays are excluded.
- If the MCO receives a **non-urgent** TPL add/update request from a provider or enrollee (past or current P or B enrollment), the MCO shall refer the provider or enrollee to the TPL contractor and provide contact information.
- When the MCO identifies TPL via claims data (an Explanation of Benefits from the primary carrier), the MCO shall verify and effectuate the verified update in its system, and process the claim. By close of business the same day, the MCO shall send the add/update record to the TPL contractor via the Daily General MCO TPL Update Request Form.
- For **urgent** TPL update requests:
    - The MCO shall be responsible for all urgent TPL update requests for P-enrolled enrollees.
        - The MCO shall verify the request and update its system within four business hours of receipt of the urgent request. This includes updates on coverage, including removal of coverage that existed prior to the enrollee's linkage to the MCO that impacts the current provider adjudication or enrollee service access (i.e., pharmacy awaiting TPL update to fulfill prescription).
        - These updates shall be submitted to the TPL contractor on the day the updates are made in the MCO's system. The updates shall be submitted via fax or e-mail on the LDH Medicaid Recipient Insurance Information Update Form. The Submission Status shall be reported as "Urgent Update: pharmacy awaiting update to fill prescription/member

[11] Except as approved by LDH. As of the original date of publication, two of the MCOs submit TPL updates directly to the fiscal intermediary.

unable to access immediate care". Urgent TPL requests originating from providers and LDH via fax and e-mail may be submitted to the TPL contractor using the same Medicaid Insurance Recipient Information update form submitted to the MCO. Missing policy and enrollee information shall be added to the request prior to sending to the TPL contractor.

- All urgent TPL requests for B-enrolled enrollees shall be sent to the TPL contractor via phone, e-mail, or fax.
  - If the MCO receives an urgent request from a provider or enrollee for a B-enrolled enrollee, the MCO shall refer the provider or enrollee to the TPL contractor and provide contact information.

POST-PAYMENT RECOVERIES FROM PROVIDERS AND LIABLE THIRD PARTIES

Post-payment recovery for third party liability (TPL)/coordination of benefits (COB) is necessary in cases where the MCO has not established the probable existence of third party liability for payments already made when a legally obligated third party is later identified.

The following requirements apply to MCOs and their subcontractors for recoveries from providers for TPL:

- The MCO or its subcontractor shall seek recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable third party.
- The MCO or its subcontractor shall seek recovery from the provider where dates of services (DOS) are 10 months or less from the date stamp on the provider recovery letter.
- The MCO or its subcontractor shall not seek recovery from the provider where DOS is older than 10 months but shall seek recovery directly from liable third parties. The MCO or its subcontractor may utilize Act 517 of the 2008 Regular Legislative Session to seek recovery of reimbursement from liable third parties for up to 36 months from the date of service reported on the claim.
- Providers shall have 60 days from the date stamp of the recovery letter to refute the recovery, otherwise recoupment from future RAs shall occur.
- Providers shall be given an additional 30 day extension at their request when the provider billed the liable third party and hasn't received an EOB.
- If after 60 days of the recovery letter, or 90 days if a 30-day extension was requested, the MCO or its subcontractor has not received a response from the provider, the recovery shall be initiated.

The provider post-payment recovery notification letter should, at a minimum, include the following:

- Provider information (provider number, provider name, provider NPI/Tax ID);
- Policy Holder information (name, policy number, group number);
- Carrier information (carrier name, address, phone);
- Type of coverage (major medical, major medical no maternity, RX only etc.);
- Patient information (name, Medicaid ID, DOB);
- Line item payment information (Medicaid claim reference number, patient Medicaid number, Medicaid remit date, dates of service, amount to be recouped);
- Recovery totals; and
- Contact information to request an extension.

The MCO shall initiate an automatic recoupment at the expiration of the 60-day period if an extension request is not received from the provider and at the expiration of the 90-day period if an extension is requested by the provider if the provider has not remitted the payment to the MCO.

Exclusions to Post-Payment Recoveries from Providers

- Pay and chase claims will always be referred directly to the liable third parties, as required in the Contract.
- Claims billed with EOB denial from other health insurance are excluded.
- If the liable third party is traditional Medicare, Tricare, or Champus VA, and more than 10 months have passed since the DOS, the MCO shall recover from the provider.
- Point of Sale (POS) will always be referred directly to liable third parties.

Encounters for Post-Payment Recoveries

The MCO shall adjust both the provider claim record and the encounter record to include the other payer payment information and report the adjusted MCO payment amount.

TPL Scope Of Coverage

The type of enrollee's other health insurance coverage is defined by LDH as scope of coverage. Scope of coverage codes with associated definitions are specified in the **MCO System Companion Guide**.

The MCO must accept scope of coverage codes from LDH's fiscal intermediary in daily and weekly TPL file transmittals. The fiscal intermediary's TPL file transmittal schedule and file layout are specified in the **MCO System Companion Guide**.

Provider Portal Response for TPL Scope of Coverage

The MCO shall provide its enrollee's scope of coverage on its provider web portal. This may be the description of the scope of coverage (e.g., Major Medical No Maternity) or the scope of coverage code associated with the description (e.g., 27).

TPL scopes of coverage are available on www.lamedicaid.com [link].

Utilization of Scope of Coverage 27 (Major Medical, No Maternity Benefits) and 33 (HMO, No Maternity Benefits)

It is possible for Medicaid beneficiaries to have Major Medical Health coverage that excludes maternity benefits. The LDH TPL contractor will assign scope of coverage (SOC) 27 to Major Medical Health Insurance Policies without Maternity Benefits and HMO Major Medical Insurance Policies without Maternity Benefits. HMO Major Medical Insurance Policies without Maternity Benefits (formerly SOC 33) has been consolidated into SOC 27.

The MCO shall not cost avoid maternity claims for enrollees with other health insurance whose Major Medical Health Insurance benefit (SOC 27) or HMO Major Medical Health Insurance benefit (SOC 27) excludes maternity

benefits. If the MCO or its subcontractor identifies TPL, it must determine if the coverage being added or updated meets the maternity exclusion.

MCOs must work with its staff and subcontractors who identify and/or verify TPL to determine if the coverage being added meets the maternity exclusion criteria.

MCOs must work with their providers to develop a process to allow providers to update the scope of coverage to 27.

*Both the diagnosis code and the TH modifier are required.

LaHIPP

LaHIPP participants may be identified in 834 eligibility files by CAP codes as specified in the Healthy LA MCO MVX COA Crosswalk or by TPL initiator code 25 in the TPL file layout as specified in the **MCO System Companion Guide**.

LDH is responsible for issuing payment for all or part of LaHIPP participants' health insurance premium.

LaHIPP enrollees are mandatorily enrolled in Medicaid managed care for specialized behavioral health services, and non-emergency medical transportation, including non-emergency ambulance transportation, unless residing in an institution. LaHIPP participants who receive coverage via the Act 421 Children's Medicaid Option are mandatorily enrolled in Medicaid managed care for all Medicaid covered services

Calculation of Payment for LaHIPP Secondary Claims

Claims processed by the MCO as secondary payer for LaHIPP enrollee claims shall be processed and paid by the MCO at the full patient responsibility (co-pay, co-insurance, and/or deductible) regardless of Medicaid's allowed amount, billed charges or TPL payment amount if the participant uses a provider that accepts the enrollee's insurance as primary payer and Medicaid as secondary payer. If the provider does not accept this payment arrangement, the participant shall be responsible for the enrollee liability. The MCO pays only after the third party has met the legal obligation to pay. The MCO is always the payer of last resort, except when the MCO is responsible for payment as primary payer for Medicaid covered services not covered by commercial insurance as primary payer (e.g., mental health and transportation services).

The following is a LaHIPP claims processing example:

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility Amount	Medicaid Payment
99213	70.00	40.00	36.13	10.00	10.00

Because this is a LaHIPP enrollee, Medicaid pays the co-pay even though the private insurance payment is more than the Medicaid allowable. Medicaid pays the patient responsibility on Medicaid covered services regardless of Medicaid's allowed amount, billed charges, or TPL payment.

NOTE: Refer to the *Resources* section for a link to the **Reinstatement and Implementation of LAHIPP Third Party (TPL) Claims Payment** manual for more LaHIPP claims processing examples.

TPL PAYMENT & TPL PAYMENT CALCULATION

If a TPL insurer requires the enrollee to pay any co-payment, coinsurance or deductible, the MCO is responsible for making these payments under the method described below, even if the services are provided outside of the MCO network.

Scenario 1 Professional Claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility Amount	Medicaid Payment
99212	55.00	0.00	24.10	36.00 (Ded)	24.10
83655-QW	30.00	0.00	11.37	28.20 (Ded)	11.37
Totals	85.00	0.00	35.47	64.20 (Ded)	35.47

The Medicaid allowed amount minus the TPL paid amount is LESS than the patient responsibility; therefore, the Medicaid allowed amount is the payment.)

Scenario 2 Outpatient Claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility Amount	Medicaid Payment
HR270	99.25	74.44	22.04	0.00	0.00
HR450	316.25	137.19	70.24	100.00	0.00
Total	415.50	211.63	92.28	100.00	0.00

(Medicaid "zero pays" the claim. When cost-compared, the private insurance paid more than Medicaid allowed amount for the procedure. When compared, the lesser of the Medicaid allowed amount minus the TPL payment AND the patient responsibility is the former; thus, no further payment is made by Medicaid. The claim is paid in full.)

Scenario 3 Inpatient Claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility Amount	Medicaid Payment
Multiple HR	12,253.00	2,450.00	5,052.00	300.00	300.00

(The Medicaid allowed amount minus the TPL payment is greater than the patient responsibility; thus, the patient responsibility is paid on this covered service.)

Scenario 4: FQHC/RHC/American Indian Clinic

Provider's PPS Rate (Medicaid allowable)	Procedure Code	Billed Charge	TPL Paid Amount	Patient Responsibility Amount	Medicaid Payment
150.00	T1015	150.00	50.00	40.00 (Ded)	100.00

Provider's PPS rate is $150.00. The third party paid $50.00. Medicaid pays the difference from the PPS rate and third party payment making the provider whole.

MCOs may not establish a cost-sharing payment methodology for enrollees with third party liability for FQHC, RHC and American Indian Clinic services at less than the Louisiana Medicaid State Plan rate (PPS). MCOs must pay the difference between the third party payment and the PPS for the service.

MCO payment = Medicaid PPS Rate - TPL paid amount

Scenario 5 Outpatient Pharmacy Claim

Amount Billed	TPL Paid Amount	Medicaid Maximum Allowable	Patient Responsibility Amount from Primary	Medicaid Pharmacy Co-Pay	Medicaid Payment
38.55	28.55	31.36	10.00 (Copay)	0.50	2.31
613.00	60.00	40.73	553.00 (Ded)	0.00	0.00
177.97	5.22	14.39	172.75 (Ded)	0.50	8.67

If third party liability (TPL) is involved, the MCO as the secondary payer may not deny the claim for a high dollar amount billed for claims less than $1,500. If the TPL pays $0.00 or denies the claim, then the pharmacy claims should be treated as a straight Medicaid pharmacy claim. Taxes on the primary claim should be subtracted before calculating the Medicaid Maximum Allowable. Maximum Medicaid allowable is defined as professional dispensing fee plus ingredient cost (quantity * price per unit) or usual and customary, whichever is less.

The pricing calculation is ingredient cost (quantity * price per unit) + Dispensing Fee – TPL amount paid – copayment = Medicaid payment. If U&C is less than the Medicaid allowable, then the calculation is U&C – TPL amount paid – copayment = Medicaid payment. If there is other third party liability (TPL) payment greater than $0.00, the MCO should electronically bypass prior authorization requirements and Point of Sale edits that would not be necessary as the secondary payer. Safety edits should still apply.

TPL claims should process with the same PCN and BIN number as primary claims.

Scenario 6: LaHIPP Enrollee Claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility Amount	Medicaid Payment
99213	70.00	40.00	36.13	10.00	10.00

Because this is a LaHIPP enrollee, Medicaid pays the co-pay even though the private insurance payment is more than the Medicaid allowable. Medicaid pays the patient responsibility on Medicaid covered services regardless of Medicaid's allowed amount, billed charges, or TPL payment.

LIENS (TRAUMA RECOVERY)

Approval Guidelines for Trauma Recovery Lien Settlements Equal to or Greater Than $25,000

The process for obtaining LDH approval for settlements on liens equal to or greater than $25,000 is as follows:

- The LDH subject matter expert (SME)/business owner for the TPL Trauma Recovery process is the point of contact for these submissions. The MCO must provide LDH with its contact for this process.
- The MCO (not its subrogation vendor) must submit these requests directly to LDH via e-mail, marked with High Importance, using the following subject format: "[MCO Name], Settlement Request".
- At minimum, the MCO must include the following in the body of the e-mail and/or in the corresponding attachment(s):
    - Enrollee's identifying information (name, SSN, Medicaid ID#);
    - DOA/DOI (Date of Accident/Date of Incident);
    - Third party (i.e., liable party/insurance companies, defense and plaintiff attorneys), with contact information;
    - MCO's lien amount;
    - Case settlement amount;
    - Requested settlement amount (suggested reduced amount);
    - Description of incident and injuries;
    - Reason for request and MCO's recommendation;
    - Other liens to be considered; and
    - Attorney's fees and expenses.
- Once received, the LDH SME/business owner will consult with LDH Bureau of Legal Services and provide its decision to the MCO's contact via secure e-mail.

Guidelines for Prior Notice of Trauma Recovery Subrogation Vendor and Process Changes

MCOs shall notify LDH of any changes to the Trauma Recovery subrogation vendor, contact, or process via e-mail at Medicaid.TraumaEstateRecovery@la.gov (cc: LDH business owner) at least 30 days prior to implementation of changes. MCOs shall provide the following information within the e-mail as applicable:

- Vendor/entity name;
- Contact person;
- Mailing address;
- Phone number;
- Fax number;
- E-mail (including for referrals from LDH); and
- Detailed process changes (e.g., effective dates, cutoff date/process for vendor transition, subpoena process server).

COORDINATION OF BENEFITS

Other Coverage Information and Third Party Liability Data Exchange

In a format and medium specified by LDH in the **MCO System Companion Guide**, the MCO shall submit to LDH or its contractor a daily TPL file reporting verified TPL additions and updates for each enrollee that has not otherwise been provided by LDH's fiscal intermediary.

The MCO shall review daily response files from LDH, or its contractor, and rejected records shall be corrected and completed within five business days.

If an enrollee is unable to access services or treatment until an update is made, the MCO shall verify and update its system within four business hours of receipt of an update request. This includes updates on coverage, including removal of coverage that existed prior to the enrollee's linkage to the MCO that impacts current provider adjudication or enrollee service access. Such updates shall be submitted to LDH and/or its TPL vendor on the Medicaid Recipient Insurance Update Form [link].

PART 10: QUALITY

LDH's **Medicaid Managed Care Quality Strategy** ("Quality Strategy") defines and drives the overall vision for advancing health outcomes and quality of care provided to Louisiana Medicaid enrollees. The MCO must have an overall quality management and quality improvement approach with specific strategies that advance the Quality Strategy and LDH's incentive-based quality measures.

LDH has also developed an **MCO Quality Companion Guide** that focuses on core quality improvement activities. The MCO shall refer to this companion guide for clarification of contract requirements and external quality review organization (EQRO) activities and processes. This includes timeline and format specifications for performance measure and Performance Improvement Project (PIP) reporting.

LDH has established the opportunity for MCOs to participate in incentive arrangements in accordance with 42 C.F.R. §438.6(b). Each incentive arrangement will include specified activities, targets, performance measures, or quality-based outcomes for a fixed length of time that support the Quality Strategy. These incentive arrangements will collectively be known as the Managed Care Incentive Payment (MCIP) program. All incentive arrangements must comply with the MCIP Program Protocol developed by LDH and the MCIP section of the Contract.

See the *Resources* section for links to the Quality Strategy and **MCO Quality Companion Guide**.

PART 11: PROGRAM INTEGRITY

Preventing and detecting Medicaid fraud, waste, and abuse requires a collaborative effort by various parties.

LDH, the Louisiana Legislative Auditor's Office, and the Office of the Attorney General are responsible for identifying and reviewing suspected incidents of fraud, waste, and abuse. This includes the preliminary investigation of credible allegations of fraud, the preliminary and full investigation of fraud, waste, and/or abuse, and any other matters necessary to comply with federal and state regulations. The Office of the Attorney General conducts criminal investigation and prosecution of fraud and abuse by providers, via its Medicaid Fraud Control Unit (MFCU), and by enrollees based on LDH and MCO referrals and complaints received from the public.

The MCO is responsible for quality review, compliance, and fraud and abuse investigation. Subjects may be MCO employees, subcontractors, providers, and enrollees. The MCO has no criminal review authority, although it may pursue civil damages, so the MCO is required to report suspected and confirmed fraud and abuse to LDH and MFCU. A summary of responsibilities is provided below.

INVESTIGATIONS

All reviews shall be completed within eight months (240 calendar days) unless an extension is authorized. Requests for extensions to investigations are to be e-mailed to LDH as needed.

REFERRALS/NOTICES

All provider and enrollee fraud and abuse must be reported to the appropriate agencies as follows:

Type	Reported To	Reporting Template
Provider (confirmed)	LDH and MCFU	MCO Fraud Referral Template
Provider (suspected)	LDH and MCFU	MCO Fraud Notice Template
Enrollee (confirmed or suspected)	LDH and local law enforcement	MCO Member Fraud Referral Template

LDH and MFCU screen all referrals for potential payment suspension. MFCU may choose to open its own investigation, or it may use the information to expand an existing investigation. For this reason, the MCO must refrain from contacting the subject of the fraud referral until LDH confirms the MCO may continue its review. There is no such prohibition on contacting the subject of a fraud notice.

REPORTING

The MCO must report all audits, overpayments identified, and recoveries by the MCO and its subcontractors, including subcontractors that pay claims (e.g., PBMs, transportation brokers), using the LDH report template.

The MCO must adjust encounters when it discovers the data is incorrect or no longer valid or that some element of the claim needs to be changed.

When overpayments associated with fraud, waste, and abuse are identified, the MCO shall start the process of voiding or adjusting claims and encounters within 14 days of being considered final, regardless of recovery status.

Overpayments are considered final when all appeals and grievances have been exhausted. All voids should be completed within 45 calendar days of the overpayment being considered final. A 45 calendar day extension will be allowed for those overpayments involving 500 or more claim lines.

TIPS

All tips regarding any potential billing or claims issue identified through complaints or internal review shall be reported to LDH by the 20th of the month.

The MCO shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse, including tips shared with the MCO by LDH in the monthly tips reports.

FWA COMPLIANCE PROGRAM

The MCO is required to implement and maintain arrangements to detect and prevent fraud, waste, and abuse. The FWA Compliance Plan is due to LDH annually and prior to changes.

LDH Program Integrity may initiate reviews of the MCO's FWA detection and prevention activities.

PROGRAM INTEGRITY MEETINGS

LDH Program Integrity hosts regular meetings to discuss fraud, abuse, waste, neglect, and overpayment issues with the MCOs and the state's Office of Attorney General MFCU, which the MCO Program Integrity Officer and CEO or COO are required to attend. The MCO's SIU investigators are encouraged to participate.

EXCLUSIONS & PROHIBITED AFFILIATIONS

The MCO may not employ or contract with an individual or entity that is debarred, suspended, or excluded from participating in any federal health care program, or with any individual or entity that is an affiliate of such an individual or entity. This includes:

- Any person with an ownership or control interest; and
- MCO staff, MCO owners, subcontractors, and network providers.

The MCO must conduct all required exclusion screenings monthly. The Exclusion Database Attestation is due to LDH by the 15th of every month. The attestation confirms that the monthly screening of providers, employees and subcontractors has been completed as required in the contract and 42 C.F.R. §455.436.

In the event payments were paid to an excluded provider, LDH may recover those funds directly from the MCO via deduction from their capitation payment. Upon identification by the state, the MCO will be given 30 days to respond and/or provide documentation that disputes the findings.

Sampling of Paid Claims

On a monthly basis, the MCO must provide individual explanation of benefits (EOB) notices to a sample group of enrollees to verify that services were received by the enrollees as billed.

The MCO shall track and investigate any complaints received from enrollees that the billed services were not rendered as stated.

The sampling of paid claims report is due 30 days after the end of the calendar year quarter.

Overpayments

MCOs may recover any overpayments identified by the MCO; however, the MCO must confer with LDH before initiating recoupment or withhold on providers previously identified through audit coordination to ensure that the recovery is permissible, meaning the funds are not already set for recovery under an open LDH or MFCU review.

Unless prior approval is obtained from LDH, the MCO must not employ extrapolation methods to derive an overpayment in a provider audit. LDH follows published CMS guidelines used by Medicare recovery contractors to determine whether an extrapolation is permissible.

Audit Coordination

Surveillance and Utilization Review Audit Coordination

Preliminary Review of Data

- LDH Program Integrity (PI) in conjunction with Surveillance and Utilization Review (SURS) reviews encounter data of all of the MCOs on a regular basis.
- If a potential overpayment is identified for a provider within the MCO's network, SURS will send a secure e-mail to the MCO for vetting.

Contact with the MCOs

- The e-mail to the MCOs will contain information pertaining to the potential overpayment. The following information may be sent depending on the information available:
  - A description of the issue(s) and provider information.
  - An attachment with the encounter data and the preliminary results of each encounter audited.
  - A copy of the draft letter containing each area of review.
- The MCO is given a deadline to indicate whether the encounter data has been or is in the process of being corrected, adjusted, or audited.

Audit Clearance

- If the issues or data anomalies relating to the providers were audited or are in the process of being audited by the MCO, SURS will need a copy of results in order for the SURS case to be closed with "no action".
- If the providers were not previously audited by the MCOs, SURS will proceed with the audits (i.e., contacting the providers, requesting records, sending recoupment letters, etc.).

Audit

- Records will be requested for the SURS analyst and/or consultants to review or encounters will be given for the provider to do a self-audit.
- All letters have contact information of the SURS analyst who is performing the audit if additional information or clarification is needed.
- If an overpayment is identified, a recoupment letter containing each area of review and the encounter-level detail is sent.

Conclusion of the Audit

- The provider has informal and appeal rights (refer to the SURS Rule and the Medical Assistance Program Integrity Law (MAPIL) for detailed information).
- If a recoupment is identified, SURS will collect the amount owed from the MCO via a deduction from the MCO's capitation payment. The MCO may pursue recovery from the provider as a result of the State-identified overpayment.
- The MCO will receive an e-mail notification from the SURS analyst that the review is complete and provide the timing of the capitation deduction.

Unified Program Integrity Contractor Audit Coordination

Preliminary Review of Data

- Program Integrity (PI) in conjunction with the Unified Program Integrity Contractor (UPIC) reviews encounter data of all of the MCOs on a regular basis.
- If a potential overpayment is identified for a provider within the MCO's network, PI will send a secure e-mail to the MCO for vetting.

Contact with the MCOs

- The e-mail to the MCO will contain information pertaining to the type/scope of the audit.
- The MCO is given a deadline to indicate whether the encounter data has been or is in the process of being corrected, adjusted or audited.

Audit Clearance

- If the issues or data anomalies relating to the providers were audited or is in the process of being audited by the MCO, those MCO claims are removed from the potential universe of claims for the UPIC case.

- If the providers were not previously audited by the MCOs, UPIC will proceed with the audit (request records, question providers/recipients, produce a final report, etc.).

Audit

- Records will be requested for UPIC to review.
- If an overpayment is identified, UPIC will produce a final report to the PI Unit. PI will draft/mail all correspondence to the provider, and enclose the final report.

Conclusion of the Audit

- The provider has informal and appeal rights. Refer to the SURS Rule and the Medical Assistance Program Integrity Law (MAPIL) for detailed information.
- If a recoupment is identified, PI will collect the amount owed from the MCO via a deduction from the MCO's capitation payment. The MCO may pursue recovery from the provider as a result of the State-identified overpayment.
- The MCO will receive an e-mail notification from the UPIC analyst that the review is complete and provide the timing of the capitation deduction.

PART 12: PAYMENT & FINANCIAL PROVISIONS

CAPITATED PAYMENTS

Capitated payments (also referred to as "PMPM payments") are the fixed payments that LDH makes to the MCO for each enrollee covered under the Contract for provision of MCO covered services. This payment is made regardless of whether the enrollee receives any MCO covered services during the period covered by the payment.

KICK PAYMENTS

Kick payments are one-time fixed payments, in addition to the capitated payment, that LDH reimburses the MCO for specific services.

For each obstetrical delivery, LDH reimburses a maternity kick payment to cover the cost of prenatal care, the delivery event, and post-partum care and uncomplicated newborn hospital costs. Kick payments may be differentiated between early elective delivery events and all other delivery events.

MCO PAYMENT SCHEDULE

The MCO should refer to the payment schedule established by LDH and published on www.lamedicaid.com.

WITHHOLD OF CAPITATED PAYMENT

LDH withholds 2% of the MCO's monthly capitated payments to incentivize quality, health outcomes, and value-based payments.

The MCO may earn back the Quality Withhold for the measurement year based on its performance relative to incentive-based measures and targets as established by LDH and specified in the Contract, prior to the start of the measurement year.

The MCO may earn back the VBP Withhold based on its reporting and performance relative to VBP requirements and targets as established by the Contract. The MCO shall report on its VBP use as directed by LDH.

MEDICAL LOSS RATIO

In accordance with the Financial Reporting Guide, the MCO shall provide an annual Medical Loss Ratio (MLR) report following the end of the MLR reporting year.

RISK SHARING

The Medicaid managed care program is a full risk-bearing, MCO healthcare delivery system responsible for providing specified Medicaid covered services included in the Louisiana Medicaid State Plan to Medicaid enrollees.

An MCO assumes full risk for the cost of covered services under the Contract and incurs loss if the cost of furnishing these covered services exceeds the payment received for providing these services.

Risk mitigation strategies established under the Contract include the following:

- Risk corridor for Hepatitis C-related pharmacy, physician, and laboratory costs; and
- Zolgensma risk pool arrangement.

Additional information about the risk corridors may be found in the Contract and the **Financial Reporting Guide**.

DETERMINATION OF MCO RATES

LDH shall establish actuarially sound capitation rates for enrollees assigned to the MCO to ensure that MCO covered services under this Contract are provided. Rates are set using available and appropriate sources, including FFS claims data, encounter data, and financial data and supplemental ad hoc data and analyses, and adjusted based on factors such as utilization trend, unit cost trend, TPL recoveries, and administrative costs.

RISK ADJUSTMENT

Capitated payments are risk adjusted, as deemed appropriate by LDH, to account for variation in health risks among participating MCOs.

RETURN OF FUNDS

LDH may deduct from the monthly capitation payment amounts owed by the MCO to LDH. LDH will provide written instruction to the MCO if funds are to be returned in any other manner.

RESOURCES

MANUALS AND GUIDES

Links to manuals and guides referenced in this Manual are provided below. Additional MCO resources are posted on the LDH website [link].

- Chisholm Compliance Guide and MCO User Manual
- DOJ Agreement Compliance Guide
- Financial Reporting Guide
- Louisiana Quality Management Strategy for the Louisiana Medicaid Managed Care Program (Quality Strategy)
- Marketing and Member Education Companion Guide
- Medicaid 834 Benefit and Enrollment EDI Transaction Set Companion Guide (834 Systems Companion Guide)
- Medicaid Services Manual
- Provider Network Companion Guide
- Quality Companion Guide
- Reinstatement and Implementation of LAHIPP Third Party (TPL) Claims Payment
- System Companion Guides, including:
    - MCO System Companion Guide
    - Batch Pharmacy Encounter Companion Guide

FEE SCHEDULES

Louisiana Medicaid FFS fee schedules are posted on www.lamedicaid.com [link].

FORMS AND TEMPLATES

Most forms referenced in this Manual may be located at www.lamedicaid.com [link].

Additional forms referenced in this Manual may be located using the following links:

- Denial and Partial Denial Notice Templates