Louisiana Department of Health
Health Plan Advisory 20-6
Revised May 6, 2022

Response to COVID-19

The directives below should be considered as continuing until rescinded by LDH.

Laboratory Testing

For patient selection and testing procedures, please refer to the recent OPH Health Alert Network Messages, located at: http://ldh.la.gov/index.cfm/page/3865.

Effective for dates of service as indicated on the COVID-19 Laboratory Testing fee schedule, Louisiana Medicaid covers commercial COVID-19 laboratory testing, without restrictions or prior authorization. The COVID-19 Laboratory Testing fee schedule is available at: https://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm.

This fee schedule contains information specific to the procedure codes, types of service, reimbursement, and effective dates of service for covered laboratory testing related to COVID-19. It will be updated as needed throughout the COVID-19 event.

Revised Effective Date of Service

Louisiana Medicaid has revised the effective dates of service for six COVID-19 laboratory testing procedure codes to align with guidance from CMS. The COVID-19 Laboratory Testing fee schedule has been updated to reflect the CMS effective dates. MCOs are to update the effective dates as needed and reprocess claims that have denied due to this issue within 15 days of the publishing of the revised fee schedule.

Procedure codes impacted:

U0002	0223U
87635	0224U
87426	0202U

Providers shall be allowed to resubmit claims if there is a date of service/procedure code conflict. To minimize administrative burden to providers, MCOs are to determine if recycling of claims is warranted.

Laboratory Testing using High Throughput Technology

Louisiana Medicaid covers laboratory testing that uses high throughput technology represented by the newly established HCPCS codes. Laboratory providers with this capacity and any required certification may submit claims for the tests performed. Relevant procedure codes and fees are available on the COVID-19 Laboratory Testing fee schedule.

Effective January 1, 2021, providers may submit claims for U0005 if tests meet the following criteria defined by CMS:

- The test is completed in two calendar days or less, and
- The laboratory completes the majority of their COVID-19 diagnostic tests that use high throughput technology in two calendar days or less for all of their patients (not just their Medicaid-insured patients) in the previous month.

MCOs are to follow standard processes to update their files accordingly, recycle claims denied, and notify impacted providers.

Serological Antibody Testing

Medicaid covers COVID-19 serological antibody testing for all enrollees when medically necessary. Relevant procedure codes are listed on the COVID-19 Laboratory Testing Fee Schedule. Serological antibody testing is covered for a maximum of two tests per year without prior authorization.

Providers should refer to CDC guidelines for test ordering and interpretation, available at: https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antibody-tests.html.

All serological antibody tests must be FDA-approved or authorized; a listing is available at: https://www.fda.gov/medical-devices/emergency-situations-medical-devices/eua-authorized-serology-test-performance.

Serological antibody testing is only covered for enrollees:
1. For evaluation of a recent past episode of symptoms to determine if the infection was from the SARS-CoV-2 virus; or
2. To assess risk of infection in an enrollee who believes that they are immune. In this case, a negative test would demonstrate continued susceptibility and provide an opportunity for

discussion about the importance of mitigation measures. Please note: By CDC guidelines, a positive test does not necessarily mean that a member is immune to infection with SARS-CoV-2.

Laboratory Testing that includes Respiratory Viral Panels

Effective March 1, 2021, respiratory viral panel tests that do not include specific SARS-CoV-2 targets, represented by CPT codes 87631, 87632 and 87633, are not covered.

Commercially available respiratory viral panel tests that do contain SARS-CoV-2 targets are covered and must be billed with the appropriate procedure code, as listed on the COVID-19 Laboratory Fee Schedule. Providers should select the most appropriate test for the diagnosis of suspected COVID-19. Use of directed testing with more narrow tests as defined by procedure codes such as 87426, 87635, U0003 or U0004 may be more appropriate in many cases.

Relevant procedure code additions have been made to the published COVID-19 Laboratory Testing fee schedule. MCOs are to follow standard processes to update their files accordingly, recycle claims denied prior to the update, and notify impacted providers.

COVID-19 Treatments

Louisiana Medicaid covers all COVID-19 treatments for which the Food and Drug Administration has issued an Emergency Use Authorization (EUA). Treatment coverage is provided without the requirement of prior authorization and with no cost sharing for enrollees.

The relevant procedure codes for treatments and treatment administration are listed on the "COVID-19 Vaccine/Treatment Fee Schedule" which will be updated as new information becomes available. See IB 21-11 for Reimbursement Updates – 2021. Coverage is provided according to the clinical criteria listed in the EUA and is effective on the date listed on the fee schedule. The MCO shall reimburse for COVID-19 treatments administered in the member's home or residence according to the fee schedule. The MCO must recycle claims and notify impacted providers as needed when the fee schedule is updated.

Currently, many treatment medications are provided at no cost to providers by the federal government and therefore those medication codes shall be reimbursed at $0. The MCO must edit claims to ensure that reimbursement is only made for treatment administration when performed appropriately, defined as:

1. The enrollee meets the age requirement on the date of service
2. The medication code matches the administration code

This policy will be updated as needed for changes in medication availability and eligibility criteria.

COVID-19 Counseling and Evaluation and Management Services
Under existing payment policies, physicians and other licensed practitioners furnishing counseling services related to COVID-19 may use evaluation and management visit codes, when applicable. When furnishing these services, physicians and other practitioners spending more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) providing counseling or coordination of care may use time to select the level of evaluation and management visit reported.

Counseling resources:
Provider Counseling Q&A: https://www.cms.gov/files/document/covid-provider-counseling-qa.pdf

Provider Counseling Talking Points: https://www.cms.gov/files/document/covid-provider-patient-counseling-talking-points.pdf

Provider Counseling Check List: https://www.cms.gov/files/document/covid-provider-patient-counseling-checklist.pdf

Handout for Patients to Take Home: https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/318271-A_FS_KeyStepsWhenWaitingForCOVID-19Results_3.pdf

COVID-19 Vaccination
Louisiana Medicaid covers all COVID-19 vaccinations for which the Food and Drug Administration has issued an Emergency Use Authorization (EUA). Vaccine coverage is provided without the requirement of prior authorization in both the medical and the pharmacy benefit and with no cost sharing for enrollees.

For clinical guidance, the MCO can refer providers to Office of Public Health advisories on COVID-19 vaccination, located at: (https://ldh.la.gov/index.cfm/page/4042).

Training tools for providers can be found here: https://ldh.la.gov/index.cfm/page/3880.

The relevant procedure codes for vaccines and vaccine administration are listed on the "COVID-19 Vaccine/Treatment Fee Schedule" which will be updated as new information becomes available. See IB 21-11 for Reimbursement Updates – 2021. A separate provider notice will be

issued with guidance for billing pharmacy claims. Coverage is provided according to the clinical criteria listed in the EUA and is effective on the date listed on the fee schedule.

Currently, vaccine doses are provided at no cost to providers by the federal government and therefore the vaccine codes shall be reimbursed at $0. The MCO must edit claims to ensure that reimbursement is only made for vaccine administration when performed and coded appropriately, defined as:

1. To enrollees meeting the age requirements on the date of service
2. The vaccine administration code matches the vaccine code (when billed as a medical claim)

MCOs are required to recycle any denied claims associated with the changes above from April 1, 2021 within 30 days.

In the event that a medically necessary exception is required, the MCO must make such allowances.

Instructions for COVID-19 vaccine administration by providers other than physicians, APRNs, and PAs are provided in the chart below. In all cases, medical documentation must be present to substantiate reimbursement.

Provider Type	**Supervision Standard**	**Rendering Provider on the Claim**
RNs and LPNs (non-APRN)	General supervision[1]	The supervising physician, APRN, or PA
Paramedics and advanced or intermediate EMTs	General supervision[1]	The supervising physician, APRN, or PA, and must be submitted on a professional claim
Respiratory therapists	General supervision[1]	The supervising physician, APRN, or PA
Phlebotomist	Direct supervision[2]	The supervising physician, APRN, or PA
Hemodialysis centers	General supervision[1]	The supervising physician, APRN, or PA, and must be submitted on a professional claim
[1]General supervision is 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.		

[2]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.

Dentists contracted with the MCOs as professional services providers may bill for the administration of COVID-19 vaccines using a hard copy or electronic professional services medical claim form.

This policy will be updated as needed for changes in vaccine availability and eligibility criteria.

Coverage of At-Home COVID-19 Vaccinations

Effective with dates of service on or after June 8, 2021, Medicaid will align with Medicare guidelines in allowing an additional reimbursement for administering the COVID-19 vaccine in the home setting. Procedure code M0201 may be used for this service and can be found on the COVID-19 Vaccine and Treatment fee schedule.

Coverage Criteria

Providers may be reimbursed the additional payment for administering the COVID-19 vaccine in enrollees' homes when either of these situations applies:

- The patient has difficulty leaving the home to get the vaccine, which could mean any of these:
    - They have a condition, due to an illness or injury, that restricts their ability to leave home without a supportive device or help from a paid or unpaid caregiver;
    - They have a condition that makes them more susceptible to contracting a pandemic disease like COVID-19; or
    - They are generally unable to leave the home, and if they do leave home it requires a considerable and taxing effort.
- The patient is hard-to-reach because they have a disability or face clinical, socioeconomic, or geographical barriers to getting a COVID-19 vaccine in settings other than their home. These patients face challenges that significantly reduce their ability to get vaccinated outside the home, such as challenges with transportation, communication, or caregiving.

Providers do not need to certify that the enrollee is homebound, but the provider must document in the patient's medical record their clinical status or the barriers they face to getting the vaccine outside the home.

Place of Service

Many types of locations can qualify as an enrollee's home for the additional in-home payment amount, including:

- A private residence;
- Temporary lodging (for example, a hotel or motel, campground, hostel, or homeless shelter);
- An apartment in an apartment complex or a unit in an assisted living facility or group home; or
- An enrollee's home that is made provider-based to a hospital during the COVID"-19 public health emergency;
- Effective August 24, 2021, communal spaces of a multi-unit living arrangement; or
- Effective August 24, 2021, assisted living facilities participating in the CDC's Pharmacy Partnership for Long-Term Care Program when their residents are vaccinated through this program.

These locations do not qualify as a home for the additional payment amount:

- Prior to August 24, 2021, communal spaces of a multi-unit living arrangement.
- Hospitals, Medicare skilled nursing facilities (SNF), and Medicaid nursing facilities, regardless of whether they are the patient's permanent residence.
- Prior to August 24, 2021, assisted living facilities participating in the CDC's Pharmacy Partnership for Long-Term Care Program when their residents are vaccinated through this program.

Vaccine Incentives

Enforcement of Section 12.7.3 of the contract between LDH and the managed care organizations will be waived partially to permit MCOs to give incentives to providers that can be given to enrollees following each COVID-19 vaccine dose. The amount per incentive may not exceed $20.00. MCOs must submit requests to utilize these incentives, together with any related materials, to mmereview@la.gov per current protocol.

Overall Telemedicine/Telehealth Policy

Louisiana Medicaid encourages the use of telemedicine/telehealth, when appropriate, for any and all healthcare services (i.e., not just those related to COVID-19 symptoms) when COVID-19-related restrictions are necessary as outlined by the governor or state public health officials. Louisiana Medicaid, including all Medicaid MCOs, allows for the telemedicine/telehealth mode of delivery for many common healthcare services. When otherwise covered by Louisiana Medicaid, telemedicine/telehealth is allowed for all CPT codes located in Appendix P of the CPT manual (relevant codes listed below).

Permissible Telecommunications Systems:
All services eligible for telemedicine/telehealth may be delivered via an interactive audio/video telecommunications system. A secure, HIPAA-compliant platform is preferred, if available.

For the duration of the COVID-19 event, in cases where an interactive audio/video system is not immediately available at the time it is needed, an interactive audio-only system (e.g., telephone) without the requirement of video may be employed, unless noted otherwise. For use of an audio-only system, the same standard of care must be met, and the need and rationale for employing an audio-only system must be documented in the clinical record. Please note, some telemedicine/telehealth services described below require delivery through an audio/video system due to the clinical nature of these services. Where applicable, this requirement is noted explicitly.

Effective with dates of service on and after June 1, 2020, "Telephone Services" represented by CPT codes 99441, 99442, and 99443 will no longer be payable under the Professional Services or Outpatient Hospital programs. Claims for audio-only interactions must be coded using the appropriate procedure codes describing the service, for example evaluation and management services, with the telehealth modifier and place of service appended.

Originating Site:
The originating site refers to where the patient is located. There is currently no formal limitation on the originating site and this can include, but is not limited to, the patient's home.

Distant Site:
The distant site refers to where the provider is located. The preferred location of a distant site provider is in a healthcare facility. However, if there is disruption to a healthcare facility or a risk to the personal health and safety of a provider, there is no formal limitation as to where the distant site provider can be located, as long as the same standard of care can be met.

Other Requirements:
As always, providers must maintain the usual medical documentation to support reimbursement of the visit. In addition, providers must adhere to all telemedicine/telehealth-related requirements of their respective professional licensing boards.

Reimbursement:
Reimbursement for services delivered through telemedicine/telehealth is at the same level as reimbursement for in-person services. This includes services delivered by an audio/video telecommunications system as well as by an audio-only system. MCOs with contracts that

exclude providers from delivering services via telehealth should amend those contracts to allow it, where clinically appropriate.

Several service-specific policies are detailed below:

- Billing instructions (non-FQHC/RHC): Providers must indicate the appropriate place of service, either 02 (other than home) or 10 (home), based on the beneficiary's location at the time of service and must append modifier -95.
- Billing instructions for FQHCs/RHCs: Providers must indicate the appropriate place of service, either 02 (other than home) or 10 (home), based on the beneficiary's location at the time of service and append modifier -95 on the header and on all detailed service lines. Services delivered via an audio/video system and via an audio-only system should are to be coded this same way. Reimbursement for these services in an FQHC/RHC will be at the all-inclusive prospective payment rate on file for the date of service.

Relevant CPT codes covered in the overall telemedicine/telehealth policy are listed below. In addition, other services are eligible to be delivered via telemedicine/telehealth (e.g., PT/OT/SLT) and these are detailed later in this bulletin.

Category	Service	CPT Code(s)
Behavioral Health	See Medicaid Health Plan Advisories posted at http://ldh.la.gov/index.cfm/page/1734.	
Dialysis	End-Stage Renal Disease Services	90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961
Cardiovascular	Cardiovascular Monitoring Services	93228, 93268, 93272
Neuromuscular	Neurostimulator Analysis-Programming	95970, 95971, 95972
Psychological, Neuropsychological Testing	Neurobehavioral Status Examination	96116

Evaluation and Management, Office or Other Outpatient Services	New Patient	99201, 99202, 99203, 99204, 99205
	Established Patient	99211, 99212, 99213, 99214, 99215
Hospital Inpatient Services	Subsequent Hospital Care	99231, 99232, 99233
Nursing Facility Services	Subsequent Nursing Facility Care	99307, 99308, 99309, 99310

Telehealth Requirements for Physical, Occupational, and Speech Therapy

Effective for dates of service on or after March 17, 2020, and for the duration of the COVID-19 event, Louisiana Medicaid encourages and will reimburse the use of telehealth, when appropriate, for rendering physical therapy, occupational therapy, and speech therapy to members. Telehealth can facilitate the continuation or establishment of these services while complying with the need for social distancing. Face-to-face visits may resume if appropriate COVID-19 protocol outlined by the governor or state public health officials is followed.

Telehealth services can be rendered for the care of new or established patients, or to support the caregivers of new or established patients. For services requiring prior authorization, a new prior authorization request does not need to meet any additional criteria to be eligible for telehealth delivery and an existing prior authorization does not need an addendum to be eligible for telehealth delivery.

Telehealth services must be rendered by licensed providers for their respective therapies, which include physical therapists, occupational therapists and speech-language pathologists, subsequently referred to collectively as the "therapy provider."

Telehealth Requirements for EarlySteps Providers

Prior to the session, the therapy provider should obtain permission from the member or caregiver to proceed with telehealth and this discussion should be documented in the clinical record. The therapy provider should also assist the member or caregiver in setting up any technology needed. The therapy provider is responsible for all aspects of the respective care provided to a patient, including determining and documenting the extent to which the use of technology is necessary and appropriate in the provision of the rendered therapy. A member's appropriateness for telehealth should be determined on a case-by-case basis, with selections

based on the judgment of the therapy provider, the member's informed choice, and professional standards of care. The therapy provider should ensure that care is provided in a secure, confidential location.

The therapy provider and member/caregiver must use an interactive audio/video telecommunications system.

Billing and Claims Processing Update:
The Louisiana Medicaid fee-for-service (FFS) claim processing system is being updated to allow the appropriate teletherapy place of service code, either 02 (other than home) or 10 (home), based on the beneficiary's location at the time of service in addition to the procedure modifier 95 ~~to no longer deny claims. All FFS claims submitted with a date of service on or after March 16, 2020, that were denied due to the use of these teletherapy codes will be recycled without any action required by providers as long as there were no other claim billing errors. This claims recycle is expected to occur on the remittance of April 28, 2020.~~

Providers must continue to include all other applicable EarlySteps procedure code modifiers (e.g., U8, TJ, or SE as applicable) on any teletherapy claims submitted. Claims submitted without the appropriate procedure code modifiers will remain in a denied status until they are corrected. Providers should correct any prior submitted claims without these modifiers in order to receive payment.

All Therapy Providers
A list of relevant procedure codes is included below. Providers must indicate the appropriate place of service, either 02 (other than home) or 10 (home), based on the beneficiary's location at the time of service and must append modifier -95.

Physical Therapy	Occupational Therapy	Speech/Language Therapy
97161	97165	92507
97162	97166	92508
97163	97167	92521
97164	97168	92522
97110	97530	92523

G0151	G0152	92524
		92526
		92610
		G0153

Telehealth Requirements for Applied Behavior Analysis (ABA)

Effective for dates of service on or after March 17, 2020, and for the duration of the COVID-19 emergency, Louisiana Medicaid will reimburse the use of telehealth, when appropriate, for rendering certain ABA services. Face-to-face visits may resume if appropriate COVID-19 protocol outlined by the governor or state public health officials is followed. LDH will determine upon resolution of the COVID-19 emergency if telehealth services should remain in place as part of the ABA program. Telehealth services can be rendered for the care of new or established patients or to support the caregivers of new or established patients.

An established patient is defined as one who already has an approved and prior authorized treatment plan. An existing prior authorization does not need an addendum to be eligible for telehealth delivery. All prior authorizations will be extended through April 30, 2021. However, new patients still require approval and prior authorization for services, and subsequent new assessments and behavior treatment plans can be performed remotely via telehealth only if the same standard of care can be met. Previously approved prior authorizations can be amended to increase units of care and/or to reflect re-assessment goals. Prior authorization requests submitted after October 31, 2020 for either new or established patients must include how telehealth will be incorporated into the behavior treatment plan, when telehealth is clinically appropriate.

The codes listed below can be performed via telehealth; however, requirements for reimbursement are otherwise unchanged from the Applied Behavior Analysis Provider Manual.

Relevant CPT codes include:
97151
97152
97153
97154
97155
97156
97157

97158

Billing Instructions:
Claims processing systems were updated by March 24, 2020. In addition to providing a CPT code, providers must indicate the appropriate place of service, either 02 (other than home) or 10 (home), based on the beneficiary's location at the time of service and must append modifier -95. Services delivered via an audio/video system and via and audio-only system ~~should~~ are to be coded this same way.

Guidance for Telehealth ABA:
Telehealth services must be based on ABA methodology and rendered or directed by a registered line technician (RLT), Licensed Behavior Analyst (LBA), or Certified Assistant Behavior Analyst (CaBA). The caregivers/patients and RLT/LBA/CaBA must be linked through an interactive audio/visual telecommunications system. If an audio/visual telecommunications system is not available, then the LBA/CaBA may use an audio system, without the requirement of video, as long as the same standard of care can be met. The need and rationale for an audio-only service should be documented in the medical record. The purpose of this service is to provide family adaptive behavior treatment guidance, which helps parents and/or caregivers properly use treatment procedures designed to teach new skills and reduce challenging behaviors. Given the rapidly changing conditions during the COVID-19 emergency, addenda to Behavior Treatment Plans can be made to increase the units approved.

Guidance for In-Person ABA Services during COVID-19 Emergency
Face-to-face provider visits may resume if appropriate COVID-19 protocol outlined by the governor or state public health officials is followed. However, providers shall consider the entire clinical picture when determining if a service can be safely converted to telehealth or postponed. It is recognized that some patients may qualify as having an "emergency medical condition" that could place the health of the individual or his/her caregiver(s) in serious jeopardy. For example, patients engaging in self-injurious behaviors, injuring others, and at risk of elopement may require in-home ABA services to prevent serious harm to themselves or others.

When considering in-person services during times of higher COVID-19-related restrictions, the provider should determine: 1) if the loss of these services will result in eminent danger for the patient and 2) the risks involved in providing such services. The provider should document evidence to support that the in-person services are provided to minimize eminent or existing danger to the patient/caregiver(s) and that the services cannot be rendered via telehealth.

Telehealth supervision of in-home therapy rendered by a RLT must utilize a LBA/CaBA to provide remote supervision. Each RLT must obtain ongoing supervision as approved in the patient's plan of care. Supervision may be conducted via an interactive audio/video telecommunications system in lieu of the LBA/CaBA being physically present. The purpose of supervision is to improve and maintain the behavior-analytic, professional, and ethical repertoires of the RLT and facilitate and maintain the delivery of high-quality services to his or her patients.

In-person ABA Encounter Requirements

All providers and patients/caregivers are strongly advised to adhere to LDH and CDC recommendations to reduce exposure to themselves, their staff, and their patients. All patients, caregivers, providers, and staff should be screened for symptoms of COVID-19, pursuant to CDC guidance. Patients (when feasible) and caregivers should wear cloth face coverings or face masks during the encounter, and providers and staff should wear surgical face masks.

Interprofessional Telephone/Internet/Electronic Health Record Services (E-Consults)

Effective for dates of service on or after March 15, 2021, Louisiana Medicaid will reimburse interprofessional assessment and management services that occur electronically through EHR, through audio/video platforms, or via telephone (e-consults).

A qualifying assessment and management service is one in which a member's treating practitioner requests the opinion and/or treatment advice of a practitioner with a specific specialty or subspecialty different from the requesting practitioner, to assist the treating practitioner in the diagnosis and/or management of the member's presenting issue. (See additional information below for CPT code 99451.)

Treating and remote/e-consultant practitioners include the following types: physicians, advanced practice registered nurses, physician assistants, psychologists, and other licensed mental health professionals.

All e-consults must be conducted through a secure internet exchange between the treating practitioner and the consultant*. The system used to complete the e-consult must, at a minimum, comply with the following requirements:

- Be in compliance with current HIPPA and other applicable security and privacy requirements;
- Enable transmission through electronic communication systems to a specialist who uses the information to evaluate the cases for the type of e-consults for which it is used; and

- Be compatible with the primary care or treating provider's electronic health records system.

*For the duration of the COVID-19 emergency, when a secure electronic exchange is not available, or the practitioners do not have a compatible electronic health record system, interprofessional assessment and management services may be rendered via audio/visual (telehealth) platforms or telephone. Practitioners must document the reason for using telehealth or telephonic communications. Documentation in the clinical records must substantiate the service.

The purpose of remote interprofessional assessment and management via e-consults, audio/visual platforms, or telephone is to replace a face-to-face evaluation and management (E/M) visits that would be performed by a practitioner with that specialty/subspecialty.

E-consult codes for interprofessional assessment and management are not reimbursable if there has been an E/M visit with the specialist/subspecialist during the time period of 14 days prior to or will be an E/M visit 14 days after the remote interprofessional assessment and management occurs (or at the next available appointment date with the specialist if that date is greater than 14 days) if:

- The E/M visit was/is related to the original issue, and
- The E/M visit is with the same specialist/subspecialist (or group) and was completed in addition to the interprofessional assessment and management.

In this circumstance, the e-consult codes shall not be billed for interprofessional assessment and management services when the specialist/subspecialist will bill for an E/M visit. In addition, e-consult codes shall not be billed for regular communication that is expected to occur between a physician and an APRN collaborating with, or a PA supervised by, the physician. Failure to adhere to this policy may result in recoupment.

All documentation for interprofessional assessment and management is to include the medical/behavioral health conclusions and any recommendations for treatment written by the specialist/subspecialist. All documentation for the interprofessional assessment and management must be retained in the member's medical record. This applies to both the treating and specialty practitioners.

Relevant CPT procedure codes are:

99451: Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified healthcare professional; 5 minutes or more of medical consultative time (used by the specialist/subspecialist clinician).

Telehealth at Outpatient Hospital Facility

Effective for dates of service on or after March 17, 2020, outpatient hospital facilities must bill telehealth claims using the normal revenue code and applicable procedure code with modifier 95 appended. The POS 02 (other than home) or 10 (home) telehealth guidance for professional claims does not apply for telehealth billing on the UB 04 Form. MCO systems must be configured to process telehealth claims in accordance with these requirements.

Secondary Claims (Third Party Liability – TPL) for Telehealth:

If a primary insurance claim for telehealth services was submitted with a place of service equal to the primary carrier's billing requirements and modifier -95 is appended to the procedure code for a covered service, ~~DXC~~ Gainwell Technologies will allow the secondary claims and encounters. Place of service (POS) 02 (other than home) or 10 (home) will not be required for these claims.

All secondary (TPL) claims submitted for effective dates of service (as described elsewhere in this document) that were denied due to invalid place of service that have modifier -95 appended to applicable procedure codes will be reprocessed without any action required by providers.

EPSDT Preventive Services Telemedicine/Telehealth Visits (Well-Child Care) during COVID-19

Effective for dates of service on or after March 5, 2020, the use of telemedicine/telehealth to perform clinically appropriate components of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) preventive services for members older than 24 months of age will be allowed. Essential components of an EPSDT preventive service visit that are impossible to perform via telemedicine/telehealth (e.g., a complete physical exam, vision and hearing screenings, fluoride varnish, laboratory tests, and immunizations) can be performed during an in-person interperiodic visit at a later date when limitations on non-emergent clinical care are lessened.

Coding for EPSDT preventive services completed through telemedicine/telehealth and interperiodic visits:

- Telemedicine/telehealth visit: Normal EPSDT preventive services code by age (99381-99385, 99391-99395) with telehealth modifier (95), reduced services modifier (52), and the appropriate place of service, either 02 (other than home) or 10 (home), based on the beneficiary's location at the time of service.
- In-person interperiodic visit: Normal EPSDT preventive services code (99391-99395).

The telemedicine/telehealth visit providing partial components of the EPSDT preventive services visit is reimbursed at 75% of the normal rate. The complete in-person interperiodic visit that occurs at a later date will be reimbursed at 100% of the fee on file.

Episodic and sick care (e.g., CPT codes 99212-99215) may be delivered by telemedicine/telehealth to members of all ages, as long as the same standard of care can be met as an in-person visit. For EPSDT preventive services and episodic and sick care, the overall Medicaid telemedicine/telehealth policy applies including, but not limited to, telecommunication system recommendations, originating site, distant site, and reimbursement rates. As always, providers must maintain the usual medical documentation to support reimbursement of the visit.

Pharmacy

Effective March 17, 2020, members may receive up to a 90-day supply, as appropriate, of medications that are not controlled substances. These include cardiovascular drugs (hypertension, coronary artery disease, thrombosis), diabetes drugs (oral and injectable), respiratory drugs (inhaled and oral), contraceptives, antiretrovirals, direct-acting antivirals for hepatitis C, immunosuppressives, antipsychotics, and antidepressants, among others. MCOs have been provided with a list of applicable drugs, by NDC. Prior authorization on prescribed drugs and physician-administered drugs should resume November 1, 2020. Additionally, member copays for prescribed drugs are waived, effective March 24, 2020.

To reduce exposure, providers should consider encouraging members to use pharmacies that offer free home delivery services or drive-through pickup services. To reduce contact, member signatures are no longer required.

Durable Medical Equipment

Effective March 17, 2020, members may receive up to a 90-day quantity of supplies related to: incontinence, diabetes, tracheostomy care, wound care, home dialysis, parenteral and enteral nutrition, apnea/breathing monitors and other respiratory supplies, home oxygen, electric breast pumps, pulse oximeter probes and tape, and intravenous therapy. A list of applicable HCPCS codes is provided at the end of this advisory. Prior authorizations previously extended

due to COVID 19 should be extended a final time through April 30, 2021. To reduce contact, member signatures are no longer required for DME delivery services.

Additionally, effective for dates of services on or after March 1, 2020, Medicaid reimburses for multifunction ventilators through the durable medical equipment benefit. This addition is to allow providers flexibility in the types of ventilators that can be utilized to meet members' needs.

Other Prior Authorized Services

All existing prior authorizations for services are extended through April 30, 2021, including:

- Any necessary medical and surgical procedures.
- Home health services (EHH).
- EPSDT personal care services (PCS).
- Hospice services.
- Therapies (PT/OT/SLT).
- Pediatric Day Health Care.

Hospital-based Utilization Management for Medical Stays

All utilization management (UM) for all medical hospitalizations including, but not limited to, initial service authorizations and concurrent reviews that were suspended may resume beginning March 21, 2022. This also applies to cases in which an individual is enrolled in an MCO retroactively. After the suspension ends, all efforts to conduct post-payment reviews of medical hospital stays during the suspension must be approved by and coordinated with LDH to minimize disruption to hospitals.

Hospitals are expected to continue to notify MCOs about admissions so that MCOs can assist with discharge planning where possible. To maximize beds available for patients with COVID-19, hospital-based staff should be dedicated to facilitating rapid placement and discharge of currently hospitalized patients. Effective January 3, 2022 through March 20, 2022, prior authorizations for lower levels of care (e.g., skilled nursing facility, inpatient rehabilitation, and long term acute care) for members being discharged from the hospital were suspended.

Home Health Services at Hospital Discharge

Effective January 3, 2022, MCOs shall automatically approve the initial authorization for home health services at hospital discharge. Instead of a prior authorization, the hospital or the home health agency will send the MCO a notification of services that an enrollee will receive after discharge and the MCO shall subsequently approve the initial authorization for services.

Quarantine/Isolation

When otherwise covered in Louisiana Medicaid, a public health quarantine or isolation order or recommendation establishes medical necessity of healthcare services. For hospital-based quarantine or isolation stays, MCOs shall not downgrade inpatient days to an outpatient level of care, and shall not deny claims for physician services, on the basis of medical necessity. In these cases, the level of care determination is at the discretion of the hospital.

Quality Programs and Value-Based Payment Programs

Participation in provider quality incentive programs and value-based payment programs have returned to pre-COVID-19 expectations. When determining provider incentives and value-based payment targets, Medicaid MCOs will base their assessments on actual provider performance.

Provider Visits and Case Management

Face-to-face provider visits and member case management may resume if appropriate COVID-19 protocol outlined by the governor or state public health officials is followed.

Social Distancing

MCOs shall protect their staff, and support ongoing continuity of operations, through implementing social distancing policies within their offices.

Submission of MCO Policies

Effective immediately pharmacy policies should be submitted to mcopharmacypolicies@la.gov. MCOs may resume submitting all non-pharmacy policies to mcopolicies@la.gov beginning March 1, 2021, in accordance with the directions provided by LDH.

Any policies that are deemed to meet the imminent peril exception in Act 319 will be immediately posted and can be enacted upon posting.

Credentialing

MCOs should follow the guidance issued by the National Committee for Quality Assurance, which includes:

Practitioners Who Provide Care During a Public Health Emergency

Organizations do not need to credential practitioners who are not part of their network or practice and are providing care to members/patients as part of a federal, state or local government emergency response team.

Accreditation and Certification Organizations

For activities where challenges to timeliness may occur, NCQA is making the following changes, effective immediately:

- Extending the practitioner and provider recredentialing cycle 2 months, to 38 months.
- Extending provisional credentialing status from 60 days to 180 days.

Member Reassignment

The quarterly member reassignment process outlined in Health Plan Advisory 19-5 shall be resumed effective October 1, 2020.

Non-Emergency Medical Transportation

The following programmatic changes are effective during the COVID-19 event only. MCOs shall notify transportation providers of these changes immediately upon the posting of this advisory:

Participation Requirements

- Providers may lease vehicles and use magnetic signage.
- Drivers may be 21 years of age or older.
- Mandated defensive driver and Passenger Assistance Safety and Sensitivity (PASS) training should be completed online. The wheelchair securement portion of PASS should be provided via a virtual platform.
- All other credentialing requirements listed in the transportation manual shall not be waived. Contracted brokers may relax requirements that are not in the transportation manual, i.e., annual training and recertification requirements.
- Virtual vehicle inspections are permitted as long as appropriate records and images are retained to document the inspection and condition of the vehicle.

Trip Requirements

- Non-emergency medical transportation is not to be used for drive-through COVID-19 testing. Members requesting COVID-19 testing should be advised to call their healthcare provider for guidance.
- Any person scheduled for transport with a fever and respiratory symptoms or who has been exposed in the last 14 days to someone with fever and respiratory symptoms should be asked to cancel their trip as soon as possible. They should be advised to call their healthcare provider, or the Office of Public Health at 211, for guidance.
- Ground, non-emergency ambulance transportation may **not** be used to transport individuals with COVID-19. For enrollees with COVID-19, MCOs and brokers must work with NEMT providers to identify means to safely transport those enrollees, including enhanced rates to account for the proper PPE, vehicle modifications, or single rider trips.

- Enrollees shall not be required to sign transportation logs or other transport-related documents.
- Contracted brokers shall not require provider signatures on gas reimbursement claims.

MCOs may authorize the transport of enrollees to pharmacies to receive the COVID-19 vaccine, and those trips are not required to be flagged as a value-added benefit (VAB). LDH will perform data analytics to verify that the enrollee did receive a vaccine on the same date of service as any pharmacy trip not flagged as a VAB. MCOs may be required to void any encounters for trips to a pharmacy without an associated vaccination.

MCOs and brokers should work with NEMT providers to ensure transportation of enrollees to obtain COVID-19 vaccines is provided regardless of the vaccination administration setting.

Treatment-in-Place by Ambulance Providers

An enrollee who is experiencing an acute medical emergency that requires medically necessary treatment in a hospital setting shall be transported to a hospital emergency department, pursuant to applicable laws and protocols. However, for the duration of the COVID-19 emergency and for enrollees that are not experiencing such a condition, the treatment-in-place service may be rendered.

Treatment-in-place consists of ambulance dispatch followed by facilitation of a telemedicine/telehealth visit in the field with a licensed physician, physician assistant, or advanced practice registered nurse. The purpose of this service is to increase the economy and efficiency of care and to increase enrollee choice in care setting. The determination of which patients and which conditions are appropriate for treatment-in-place must comply with all state and local laws and occur under protocols established and supervised by a licensed physician serving as the ambulance provider's medical director.

The licensed physician, physician assistant, or advanced practice registered nurse shall be reimbursed for professional services rendered under the general telemedicine/telehealth policy. For all services rendered, licensed physicians, physician assistants, and advanced practice registered nurses must adhere to all existing clinical policies, must indicate the appropriate place of service, either 02 (other than home) or 10 (home), based on the beneficiary's location at the time of service, and must append modifier -95 to indicate telemedicine/telehealth.

A "Physician-Directed Treatment-in-Place" fee schedule is available on the Medicaid website: https://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm. This fee

schedule contains information specific to the procedure codes and reimbursement for these services.

Billing and Payment Guidelines for Treatment-in-Place by Ambulance Providers
Telehealth services must be separately billed from ambulance service.

Ambulance providers must indicate treatment-in-place destination code "W" in the destination position of the origin/destination modifier combination. Supply codes A0382 and A0398 are payable but mileage (A0425) is not payable. Ambulance treatment-in-place claims billed with mileage (A0425) shall be denied.

If a patient being treated in place has a real-time deterioration in their clinical condition necessitating immediate transport to an emergency department, the ambulance provider cannot bill for both the treatment in place ambulance service and the transport to the emergency department. **In that case, the ambulance provider shall bill only for the emergency department transport.**

Approved Ambulance Modifiers for Treatment-in-Place Services

Modifier	Origination Site	Destination
DW	Diagnostic or therapeutic site other than P or H when these are used as origin codes	Treat in Place
EW	Residential, domiciliary, custodial facility (other than 1819 facility)	Treat in Place
GW	Hospital based ESRD facility	Treat in Place
HW	Hospital	Treat in Place
IW	Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport	Treat in Place
JW	Freestanding ESRD facility	Treat in Place
NW	Skilled nursing facility	Treat in Place
PW	Physician's office	Treat in Place
RW	Residence	Treat in Place

SW	Scene of accident or acute event	Treat in Place

Treatment in Place MCO Encounter Submissions:
Encounters for ambulance treatment in place and ambulance transport services must be submitted to the state's FI using .TRA file extension.

Treatment-in-Place telehealth professional services must be submitted to the state's FI using .PHY file extension.

Ambulance Treatment-in-Place and Transport Claim Denials
Pre-Hospital Care Summary Reports should be submitted to the payer for reconsideration of claim denials when unique occurrences of multiple treatment in place or treatment in place and transport services are rendered on the same date of service for the same recipient, and same billing provider.

Appendix: DME HCPCS Codes Eligible for a 90-day Supply

Incontinence Supplies				
A4310	A4357	A4385	A4405	T4521
A4311	A4358	A4387	A4406	T4522
A4320	A4360	A4388	A4407	T4523
A4322	A4361	A4389	A4408	T4524
A4326	A4362	A4390	A4409	T4525
A4327	A4364	A4391	A4410	T4526
A4328	A4367	A4392	A4411	T4527
A4331	A4368	A4393	A4413	T4528
A4332	A4369	A4397	A4414	T4529
A4335	A4371	A4398	A4415	T4530
A4336	A4372	A4399	A4416	T4531
A4338	A4373	A4400	A4417	T4532
A4344	A4375	A4402	A4418	T4533
A4349	A4376	A4404	A4419	T4534
A4351	A4377		A4421	T4535
A4352	A4378		A4422	T4539
A4353	A4379		A4423	T4543
A4354	A4380		A4424	
A4355	A4381		A4425	

A4356	A4382		A4426	
	A4383		A4427	
	A4384		A4428	
			A4429	
			A4431	
			A4432	
			A4433	
			A4434	

Wound Care Supplies			
A4450	A6210	A6245	A6506
A4452	A6211	A6246	A6507
A4455	A6212	A6247	A6508
A4456	A6213	A6248	A6510
A4459	A6214	A6250	A6511
A4461	A6215	A6251	A6513
A4463	A6216	A6252	K0744
A5120	A6217	A6253	K0745
A5121	A6218	A6254	K0746
A5122	A6219	A6255	
A6021	A6220	A6256	
A6022	A6221	A6257	
A6023	A6222	A6258	
A6024	A6223	A6259	
A6025	A6224	A6260	
A6154	A6228	A6261	
A6196	A6229	A6262	
A6197	A6230	A6266	
A6198	A6234	A6402	
A6199	A6235	A6403	
A6203	A6236	A6404	
A6204	A6237	A6410	
A6205	A6238	A6446	
A6206	A6241	A6501	
A6207	A6242	A6502	
A6208	A6243	A6504	
A6209	A6244	A6505	

Apnea and Breathing Monitors
A4556
A4557
E0619

Electric Breast Pumps
A4281
E0603

Diabetic Supplies
A4224
A4225
A4230
A4231
A4233
A4234
A4235
A4236
A9274
A9276
A9277
A9278
E0607

Home Dialysis Supplies
A4690
A4730
A4740
A4750
A4755
A4760
A4765
A4860
A4913

Home Oxygen
A4615
A4616

A4618
E0430
E0431
E0433
E0439
E0443
E0444
E0447
E0565
E1358
E1390
K0738

Tracheostomy Care Supplies	
A4481	A4627
A4483	A4628
A4611	A4629
A4612	A7048
A4613	A7501
A4613	A7502
A4614	A7520
A4615	A7521
A4616	A7522
A4618	A7524
A4618	A7525
A4620	A7526
A4623	A7527
A4624	E0600
A4625	

Parenteral and Enteral Nutrients and Supplies
B4034
B4035
B4036
B4081
B4082
B4083
B4088
B4100

B4102-B4104
B4149-B4150
B4152-B4155
B4158-B4162

Pulse Oximeter Probes and Tape
A4606
E0445

Intravenous Therapy
S1015

Respiratory Supplies
A7003
A7005-A7009
A7012-A7017
E0470
E0471
E0480
E0482
E0483
E0570
E0585