Louisiana Department of Health
Health Plan Advisory 20-6
Revised March 30, 2020

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The directives below should be considered as continuing until rescinded by LDH.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 on or after March 5, 2020, Louisiana Medicaid covers commercial COVID-19 laboratory testing, without restrictions or prior authorization, for members that have symptoms compatible with COVID-19.

The relevant procedure code is:
U0002: 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19) using any technique, multiple types or subtypes (includes all targets)

This code has been added to the Medicaid procedure file.

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). 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. However, for the duration of the COVID-19 event, if a HIPAA-compliant system is not immediately available at the time it is needed, providers may

use everyday communications technologies such as cellular phones with widely available audio/video communication software.[1]

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.

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. 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 place of service 02 and must append modifier -95.
- Billing instructions for FQHCs/RHCs: Providers must indicate place of service 02 and append modifier -95 on the header and on all detailed service lines. Services delivered

[1] Providers should follow guidance from the Office for Civil Rights at the Department of Health and Human Services for software deemed appropriate for use during this event.

via an audio/video system and via and audio-only system should 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/1198.	
Dialysis	End-Stage Renal Disease Services	90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961
Cardiovascular	Cardiovascular Monitoring Services	93228, 93268, 93272
Psychological, Neuropsychological Testing	Neurobehavioral Status Examination	96116
Evaluation and Management, Office or Other Outpatient Services	New Patient	99201, 99202, 99203, 99204, 99205
	Established Patient	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.

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."

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 instructions: Claims processing systems will be updated by March 24, 2020. Before that date, providers should continue to submit claims and they will be recycled with no action needed by the provider.

All Therapy Providers

A list of relevant procedure codes is included below. Providers must indicate place of service 02 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
		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 event, Louisiana Medicaid encourages and will reimburse the use of telehealth, when appropriate, for rendering certain ABA services.

Telehealth services are only to be rendered for the care of established patients or to support the caregivers of 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. Requirements for reimbursement are otherwise unchanged from the Applied Behavior Analysis Provider Manual.

Telehealth for Family ABA Treatment Guidance: Telehealth family guidance based on ABA methodology must be rendered by a Board-Certified Behavior Analyst (BCBA). The family/patient and BCBA must be linked through an interactive audio/visual telecommunications system. If an audio/visual telecommunications system is not available, then the BCBA 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 to properly use treatment procedures designed to teach new skills and reduce challenging behaviors. Given the rapidly changing conditions during the COVID-19 event, addenda to Behavior Treatment Plans can be made to increase the units approved.

Relevant procedure code:

- 97156 (Family Adaptive Behavior Treatment Guidance, administered by QHP (with or without patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes).

Telehealth Direction of an ABA Technician Delivering In-Home Therapy: Therapy rendered by an in-home behavior technician (BT) is discouraged while social distancing is necessary for COVID-19 containment. However, if other service delivery options are not available to meet members' needs, then this modality may be employed.

Telehealth supervision of in-home therapy rendered by a BT must utilize a BCBA to provide remote supervision. Each BT must obtain ongoing supervision as approved in the member's plan of care. Supervision may be conducted via an interactive audio/video telecommunications system in lieu of the BCBA being physically present.

The purpose of supervision is to improve and maintain the behavior-analytic, professional, and ethical repertoires of the BT and facilitate and maintain the delivery of high-quality services to his or her clients. Relevant procedure code:

- 97155 (Adaptive Behavior Treatment with Protocol Modification, administered by QHP, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes).

In-home BTs should, where possible, 1) wash their hands when entering the home and prior to leaving; 2) cough into their elbow; and 3) avoid touching their own face or the member's face.

Billing instructions: Claims processing systems will be updated by March 24, 2020. Before that date, providers should continue to submit claims and they will be recycled with no action needed by the provider. Providers must indicate place of service 02 and must append modifier -95. Services delivered via an audio/video system and via and audio-only system should be coded this same way.

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

Effective for dates of service on or after March 19, 2020, 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.)

This policy also applies to services rendered by a member's treating practitioner to facilitate the specialty/subspecialty practitioner's assessment. (See additional information below for CPT code 99452.)

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, as 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. 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)

- **99452**: Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified healthcare professional; 30 minutes (used by the requesting primary care provider or treating practitioner)

Pharmacy

Effective March 17, 2020, members may receive early refills and 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. Existing prior authorizations on prescribed drugs and physician-administered drugs will also be extended through June 30th, 2020, with no action needed by the prescriber. 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. Existing prior authorizations are extended through June 30, 2020. To reduce contact, member signatures are no longer required for DME delivery services.

Additionally, effective for dates of services on or after March 23, 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 June 30, 2020, 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
Effective March 17, 2020, and for the duration of the COVID-19 event, Medicaid MCOs have been instructed to suspend all hospital-based utilization management for medical hospitalizations including, but not limited to, service authorizations and concurrent reviews. The purpose of this suspension is to ensure that all available hospital staff with clinical training can be deployed for response efforts. After the event period, Medicaid MCOs have been directed that all efforts to conduct post-payment reviews of medical hospital stays during the event period must be approved by and coordinated with LDH to minimize disruption to hospitals.

Where possible, hospitals should continue to notify MCOs about admissions so that MCOs can assist with discharge planning. To maximize beds available for patients with COVID-19, Medicaid MCOs have been directed, to the maximum extent possible, to dedicate their

hospital-based staff to facilitating rapid placement and discharge of currently hospitalized patients. MCOs have been directed to lift service authorizations for services necessary to ensure a safe discharge such as home health services and skilled nursing facility 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 will not be negatively affected by the disruption caused by COVID-19. When determining provider incentives and value-based payment targets, Medicaid MCOs will account for the effects of COVID-19 on the healthcare system.

Provider Visits and Case Management
All face-to-face provider visits by MCO staff should be discontinued. All face-to-face member case management should be transitioned to telephonic or audio/visual encounters.

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
Only policy changes reducing administrative burden, removing service authorizations, or increasing access to care should be sent to mcopolicies@la.gov for the duration of the COVID-19 event.

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

During the COVID-19 event, the quarterly member reassignment process outlined in Health Plan Advisory 19-5 will be suspended.

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.
- Providers are not required to obtain for-hire license plates.
- Drivers may be 21 years of age or older.
- Mandated defensive driver training may be accomplished online.
- All other credentialing requirements listed in the transportation manual may not be waived. Brokers may relax requirements that are not in the transportation manual, i.e., annual training and recertification requirements.

Trip Requirements

- Effective 3/27/2020, providers may transport enrollees to the following services **only**:
    - Dialysis
    - Radiation
    - Chemotherapy
    - Physical therapy
    - Occupational therapy
    - Speech therapy
    - Substance use disorder treatment
    - Counseling

- Prior to transport, the transportation broker shall verify provider offices are open, as many are closing for the purpose of social distancing and to minimize risk to susceptible individuals.
- Prior to transport, the transportation broker shall verify providers have approved and recommended receipt of the service and that it cannot be postponed.
- Non-emergency medical transportation is not to be used for 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.
- If an appointment cannot be postponed or if a provider calls to request their patient be present for services, then the transport request is to be honored even if outside of the list of services referenced above.
- Ground, non-emergency ambulance transportation may be used to transport individuals with COVID-19.
- Enrollees may not be required to sign transportation logs or other transport-related documents.

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