Post-Operative Programming

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

Community Health Workers

The MCO shall cover services rendered to enrollees by qualified community health workers (CHW) meeting the criteria and policy outlined below.

Community Health Worker Qualifications

A qualified Community Health Worker is defined as someone who:

- Has completed state-recognized training curricula approved by the Louisiana Community Health Worker Workforce Coalition; or
- Has a minimum of 3,000 hours of documented work experience as a CHW.

The MCO shall require providers who employ CHWs to verify and maintain and provide documentation, as requested by LDH, that qualification criteria are met.

Eligibility Criteria

The MCO shall cover CHW services if an enrollee has one or more of the following:

- Diagnosis of one or more chronic health (including behavioral health) conditions;
- Suspected or documented unmet health-related social need; or
- Pregnancy.

Covered Services

Covered services include:

- Health promotion and coaching. This can include assessment and screening for health-related social needs, setting goals and creating an action plan, on-site observation of enrollees' living situations, and providing information and/or coaching in an individual or group setting.
- Care planning with the enrollee and their healthcare team. This should occur as part of a person-centered approach to improve health by meeting an enrollee's situational health needs and health-related social needs, including time-limited episodes of instability and ongoing secondary and tertiary prevention.
- Health system navigation and resource coordination services. This can include helping to engage, re-engage, or ensure patient follow-up in primary care; routine preventive care; adherence to treatment plans; and/or self-management of chronic conditions.

Services must be ordered by a physician, advanced practice registered nurse (APRN), or physician assistant (PA) with an established clinical relationship with the enrollee. Services must be rendered under this supervising provider's general supervision, defined as under the supervising provider's overall direction and control, but the provider's presence is not required during the performance of the CHW services.

The MCO shall not restrict the site of service which may include, but is not limited to, a health care facility, clinic setting, community setting, or the enrollee's home. The MCO shall permit delivery of the service through a synchronous audio/video telehealth modality.

The MCO shall reimburse only the CPT procedure codes in the 'Education and Training for Patient Self-Management' section that are provided by CHWs. The MCO shall direct CHWs to follow CPT guidance.

Coverage Limitations

The MCO shall not cover the following services when provided by CHWs:

- Insurance enrollment and insurance navigator assistance;
- Case management;
- Direct provision of transportation for an enrollee to and from services; and
- Direct patient care outside the level of training an individual has attained.

The MCO shall reimburse a maximum of two hours per day and ten hours per month per enrollee.

Reimbursement

The MCO shall reimburse CHW services "incident to" the supervising physician, APRN, or PA.

The MCO shall require a CHW who provides services to more than one enrollee to document in the clinical record and bill appropriately using the approved codes associated with the number of people receiving the service simultaneously. This shall be limited to eight unique enrollees per session.

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.