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Date	Item Number and Policy	My question/comment
4/24/2025 9:06	2025-LHCC-2614-Leveling of ER Services	I am writing on behalf of the Emergency Department Practice Management Association (EDPMA) in response to the recent draft implementation of the Leveling of Emergency Room Services payment policy (Reference Number: LA.PP.053) as outlined on the Louisiana Department of Healthâ€™s website, under Medicaid Managed Care Policies & Procedures notices for public comment. While we understand the need for appropriate coding and reimbursement practices, we are concerned about how this policy may inadvertently violate the Prudent Layperson Standard (PLP), which safeguards patientsâ€™ rights to access emergency care without the immediate capacity to assess the complexity of their conditions. The Prudent Layperson Standard (PLP), which has been the standard for Medicare and Medicaid managed care plans since 1997 , including Louisiana state law regarding emergency medical services , stipulates that an individual's need for emergency medical services should be determined based on their perspective rather than the clinical judgment of physicians. Emergency departments must be prepared to handle cases that may be presented as less complex but can escalate in severity unexpectedly. By enforcing a system that reduces reimbursement for what are labeled as lower-level diagnoses, we may inadvertently discourage emergency physicians from performing necessary evaluations for patients who might still experience serious health conditions. Additionally, there needs to be human oversight with any AI algorithm that is developed, specifically by a physician who practices emergency medicine. The coding algorithm developed as part of this policy, while based on a review of emergency department records, raises significant concerns regarding transparency. The lack of clarity on how this algorithm operates, including the specific criteria used to classify diagnoses into various levels of complexity, limits our ability to understand the rationale behind these reimbursement decisions. This ambiguity creates uncertainty not only for healthcare providers but also for patients who depend on fair and accurate evaluations of their conditions. Thus, the involvement of an experienced emergency physician in overseeing the algorithm's implementation and operation is crucial to ensure that ethical standards are upheld and that decisions are made with a comprehensive understanding of clinical nuances. Patients seeking emergency care may not be aware of the exact nature of their condition, and as such, they may present with symptoms that require thorough evaluation. By penalizing physicians for coding higher levels of complexity, we risk compromising patient safety and the very essence of prudent medical judgment in emergency care.

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		Moreover, the current policy could lead to a chilling effect on healthcare providers, potentially discouraging them from prioritizing urgent diagnostic measures that are critical for patient health. When reimbursement is contingent upon a diagnosis that fits within a predefined categorization of complexity, it may result in undertreatment or delay in addressing urgent medical needs. I urge the Louisiana Department of Health to reconsider the implementation of this payment policy in light of the clear violation of the Prudent Layperson Standard (PLP) for federal and state law. It may be beneficial to establish a review process that allows for a more nuanced assessment of services rendered in emergencies, reflecting the unpredictable nature of patient presentations. Furthermore, increased transparency regarding the algorithm and its criteria would enable providers to better understand and communicate the basis for reimbursement decisions, fostering greater trust and collaboration. Thank you for your attention to this matter. I look forward to your response and to the possibility of collaboratively addressing these important issues.

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4/23/2025 23:40	2025-LHCC-2614-Leveling of ER Services	I oppose this rule change. If you threaten patients that their insurance won't cover services then you are going to have ncreased morbidity and mortality because patients will be afraid to go to the hospital. Prime example: chest pain. The average person over the age of 35 should present to an emergency room if they are experiencing chest pain. Some patients may end up staying home because they convince themselves they have reflux. They may actually have reflux. OR they may have a heart attack. There is a reason why EKGs in ERs should be done within 10 minutes. Chest pain from a heart attack is bad. But, we won't know unless we do the workup. Toe pain could be an aortic dissection. Hip pain could be a bladder obstruction. Shortness of breath may be a pulmonary embolism or a pollen allergy. Chest pain may be a heart attack or reflux. Abdominal pain may be appendicitis or gastritis. Dizziness may be stroke, cardiac arrhythmia, dehydration, anemia, vertigo. And the list goes on. The reality is patients are not medically trained. They should be able to go to the emergency department for concerning chief complaints. Emergency physicians should be able to do appropriate and necessary workups. Maybe if we had a better health care system then patients would not end up in the ERs. But, we don't. There are not enough primary care physicians to take care of all Louisianians. So they end up in the ER when they have ignored problems that may have been addressed earlier if they did have primary care physicians.

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		This regulatory change is bad for Louisiana's health.
4/23/2025 10:55	2025-LHCC-2614-Leveling of ER Services	Louisiana should not be seeking to "level," or down code emergency physicians for the work we do. We provide significant amounts of uncompensated care and are the front door to most hospitals. We absorb the insufficiencies of health systems and continue to do more and more with less and less. Please reconsider this bad policy and affront to the safety net of the US healthcare system.
4/22/2025 13:44	2025-LHCC-2614-Leveling of ER Services	On behalf of its member hospitals and health systems, the Louisiana Hospital Association (LHA) appreciates the opportunity to provide comments on proposed MCO policies. 2025-LHCC-2614 should be denied by the Department. It is inappropriate to allow algorithmic Medicaid Managed Care Organization (MCO) decision-making that appears to be in conflict with the Centers for Medicare & Medicaid Services guidelines hospitals follow for coding ED services. Additionally, the fact that one of the stateâ€™s contracted Medicaid MCOs desires to change the nature of a filed claim or the state plan-specified reimbursement for those services should greatly concern the Department. Allowing an MCO to reduce payment of a claim through administrative hassle only benefits the MCO financially. Lastly, the insertion of a new layer of administrative burden, appeals and record provision, and time value of money lost in chasing the MCO benefits no one except the Medicaid MCOs. Rather than create access and appropriately manage care coordination as specified in their contract with the state, the MCO wishes to deploy schemes to manage payment and implement tactics to

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		delay/deny payment to community providers. Again, the LHA respectfully requests that LDH deny the implementation of this obfuscatory policy.
4/22/2025 13:25	2025-LHCC-2613-30 Day Readmission	On behalf of its member hospitals and health systems, the Louisiana Hospital Association (LHA) appreciates the opportunity to provide comments on proposed MCO policies. 2025-LHCC-2613 should be denied by the Department. LDH historically recognized this proposed scheme, previously opined that the Medicaid program has no policy or practice of denying readmissions, and provided reference to its own MCO manual, as well as 42 CFR Â§ 438.210. (October 2018 LDH Letter, May 2019 LDH Letter). MCO denials for days late in hospital stays are commonplace, yet our members continue to report that the MCOs consistently fall short in the provision of lower levels of care and efficiently moving patients into other components of the care spectrum, both of which are potential factors in readmissions, especially in behavioral health. Hospitals are accustomed to working with Medicare to reduce readmissions, and if LDH wishes to explore a meaningful alternative to MCO denials, the industry stands ready to engage in a thoughtful and data driven approach. Again, the LHA respectfully requests that LDH deny the implementation of this misguided proposal that is aimed more at managing payment versus managing care.
4/22/2025 9:17	2025-LHCC-2614-Leveling of ER Services	This proposal would be in violation of the prudent layperson law. It would unfairly undermine the physicians ability to properly workup and evaluate high risk conditions just because the final diagnosis is on a list of what the insurance company deems as lower risk (Level 3) after the fact. Imagine you are evaluating an 70 year old female patient with history of heart attack, diabetes, high cholesterol and hypertension for chest pain - their initial complaint. But after working them up with x-rays, EKG, and lab tests to rule out a heart attack your final diagnosis is reflux (GERD - gastroesophageal reflux disease). The insurance company would want to down code this to a level 3 based solely on the final diagnosis and not taking into account the work and thought processes used to rule out a potential heart attack. The problem is this is not how emergency medicine works. By law, EMTALA, we have to evaluate and work up everyone who presents regardless of insurance status and rule out life threatening conditions to stabilize and rule out an emergency medical condition. The prudent layperson law was put in place to protect doctors and hospitals and allow them to be reimbursed for the work that it takes to follow the rules of EMTALA. Please do not consider allowing this proposed policy change to take place.

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Date	Item Number and Policy	My question/comment
4/21/2025 11:37	2025-LHCC-2614-Leveling of ER Services	I am writing to express concerns about the proposed changes outlined in LHCC 2614, particularly regarding their potential impact on emergency medicine billing practices and the Prudent Layperson Standard. The Prudent Layperson Standard ensures that individuals seeking emergency care are evaluated and reimbursed based on their presenting symptoms, not solely on the final diagnosis. This standard is crucial in emergency medicine, where initial symptoms can be indicative of life-threatening conditions requiring immediate attention. For instance, a patient presenting with slurred speech may undergo a comprehensive stroke evaluation, including imaging and specialist consultations. If the final diagnosis is hypoglycemia, the resources utilized remain significant, and the care provided was appropriate given the initial presentation. Under LHCC 2614, there is concern that reimbursement may be reduced in such cases, not reflecting the intensity and necessity of the services rendered. Similarly, elderly patients who experience head trauma may receive CT scans to rule out intracranial hemorrhage. Even if the final diagnosis is a concussion, the initial assessment and interventions are consistent with best practices to ensure patient safety. By potentially tying reimbursement more closely to final diagnoses rather than presenting symptoms, LHCC 2614 may inadvertently: â€¢ Undervalue necessary and appropriate emergency evaluations. â€¢ Disincentivize thorough assessments due to concerns about reimbursement. â€¢ Increase administrative burdens as providers may need to justify care retrospectively. â€¢ Compromise patient safety by discouraging comprehensive evaluations. I urge CMS to consider these implications and ensure that any changes uphold the principles of the Prudent Layperson Standard, adequately compensate providers for necessary emergency services, and maintain the integrity of patient care.

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		Thank you for the opportunity to comment on this important matter.
4/21/2025 6:59	2025-LHCC-2614-Leveling of ER Services	This policy will negatively affect the citizens of Louisiana. Reducing payment for services and resources that have already been allocated and performed is wrong and violates the prudent layperson standard of healthcare. Patients present to emergency departments daily with complex issues requiring extensive evaluation and thankfully, less than life threatening diagnosis are sometimes made. The doctor and patient should not be punished. The reduction in payment to doctors and hospitals will incentivize less thorough evaluations leaving the patient in a bad spot. Our state should be working to create a more friendly environment for administering healthcare to its citizens, not putting up continual roadblocks. EMTALA, a federal law, requires evaluation to determine if an emergency medical condition is present, and the the planned state "Leveling of ER Services" would cause negative effects within LA. If this process goes forward I would expect the state to see LESS available emergency medicine coverage which is already severely strained in Louisiana. Anyone who had had to be in and emergency department waiting room knows how strained this system is and it will only get worse.

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Date	Item Number and Policy	My question/comment
4/19/2025 8:16	2025-LHCC-2614-Leveling of ER Services	It is deeply concerning that, under this proposal, a patient can present to the ER for what they perceive as life-threatening chest pain, receive all of the same expedited triage and testing as life-threatening chest pain, but then if the patient's tests point in another direction, such as reflux, the state will only pay the same rate as a patient with mild fever and a positive COVID test with no other symptoms.
4/17/2025 12:10	2025-LHCC-2614-Leveling of ER Services	I am in opposition to the Louisiana Medicaid proposal â€œLeveling of ER Servicesâ€. There are many reasons for the increased numbers of charts billed at 99284 and 99285 for emergency medicine services. In January 2023, CMS changed the coding requirements for EM charts, from having to contain certain numbers of bullet points in different parts of the chart, and moved to using the â€œMedical Decision Makingâ€ part of the chart the most important. Physicians now have to document what they were thinking, why they ordered tests, their interpretation of tests, chosen diagnosis and risks, any shared decision making, etc. This actually allows us to bill for what we did, instead of possibly missing out on bullet points. Following this nationally, there is data in all states to show the increased billing levels as it is not just a Louisiana issue. It is not a poor integrity problem, and not a greed issue. Also, because of the lack of primary care nationally, more patients are showing up to EDs with later disease presentations, causing more extensive workups and evaluations. Additionally, requiring billing downcoding based on the final diagnosis is not consistent with the Medicaid Actâ€™s prudent layperson standardâ€ when the physicians and hospitals have furnished more extensive services covered by higher CPT codes. With this, prudent layperson patients present to the ED with the complaint of chest pain, and need extensive work up to determine if this is or is not a dangerous cause of chest pain. If it is deemed not to be, and possibly a diagnosis of GERD, the entire evaluation still had to be done for the patientâ€™s safety. If it would not be covered by the insurer, this would possibly lead to fewer workups and serious missed diagnoses. Unfortunately, patients and physicians do not know the cause of symptoms on initial presentation and need ED evaluation. Prudent layperson laws were created to protect patients, and this needs to stand in this case as well. This is dangerous for patients.

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4/12/2025 18:24	2025-UHC-1849-Upper Extremity Myoelectric Prosthetic Devices	Medically Necessary The proposed updates noted in 2025-UHC-1873 and 2025-UHC-1849 include the elimination of the current definition of "medically necessary," which could have serious negative consequences on both patients and insurance companies. We suggest adopting the â€œmedically necessaryâ€ definition put forth by the American Medical Association (AMA) (1). For enrollees, the lack of clarity on what is medically necessary can lead to delays or denials of essential treatments resulting in worsening health conditions, increased suffering, and potentially life-threatening events. Individuals who are fitted with a prosthesis after a traumatic amputation have a higher return-to-work rate than those who are not fitted with a prosthesis (2). Additionally, the success rate of rehabilitation is 93% for individuals fitted with a prosthesis within 1 month of their amputation and only 42% if fitted after 1 month (3) Therefore, it is in the best interest of all stakeholders to have Medicaid enrollees fit with a prosthesis in a timely manner. Furthermore, although only 8% of Medicare beneficiaries are black, they account for a disproportionate 21% of those who have experienced limb loss (4). By adopting a clear and trusted standard like the AMA definition of â€œmedically necessaryâ€, UHC can help address these inequalities by ensuring equitable access to necessary services. VA Study Cited on Page 13 The Department of Veterans Affairs/Department of Defense Clinical Practice Guidelines cited on page 13 of the policy references the guidelines for lower limb amputation. This policy is for the upper limb population. Bone Anchored Percutaneous Limb Prostheses Osseointegration procedure, when applied to the appropriate patient, can create a viable prosthetic option for individuals that are unable to tolerate a socket-suspended prosthesis due to the shape and composition of their residual limb. And, while the evidence on osseointegration continues to advance, early potential benefits for the appropriate patient indicate improved mobility, higher return to work, better quality of life, and increased patient satisfaction. While the procedure may not be approved by Louisiana Medicaid, the UHC managed Medicaid policy should consider covering prosthesis benefits based on the persistent demand for osseointegration by a particular group of people with limb loss and limb difference and thereby ensure that these enrollees are not left without viable prosthetic options. Myoelectric Hand, Partial-Hand, or Artificial Digits Prosthetic devices described by HCPCS Codes L6880 and L7181 address specific functional needs for individuals with upper limb amputations:

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		â€¢ L6880: An electric hand with independently articulating digits, controlled via switches or myoelectric signals. This device supports various grasp patterns or combinations of patterns and includes motor(s) to enhance functionality. â€¢ L7181: An electronic elbow that uses microprocessor technology to allow simultaneous control of the elbow and terminal device, improving coordination and usability. There are multiple references to the Hayes, 2023 analysis in the proposed policy change. This was a private report by Hayes Inc., that states on their website they â€œmake it easier for health plans to makeâ€¦defensible choices for coverage policy, utilization management, and appeals decisions by using our evidence resources and personalized support (5).â€ Without reliance on peer-reviewed evidence, there is increased risk of influence from bias. According to a consensus of clinical standards of care in regard to prosthetic management of unilateral transradial amputation, an externally powered prosthesis such as a myoelectric device, is appropriate when the patient meets specific criteria such as lacking the strength and range of motion for a body-powered prosthesis. Additionally, the myoelectric device is necessary if the patient requires sustained high grip strength and has previously struggled with other prosthesis types. If a myoelectric device is essential for their daily activities and overall well-being, then the device is necessary for proper clinical care and enhances the overall function and independence of the enrollee (6). Similarly, the Veteransâ€™ Affairs clinical care guidelines (cited in this document) mention the use of a myoelectric prosthesis 59 times in their Clinical Practice Guidelines for the Management of Upper Extremity Amputation (7). Within these guidelines are several benefits such as greater functionality, greater degrees of freedom, and individually powered digits. These guidelines are highlighted further in the peer reviewed literature. One example is an updated systematic literature review investigating the differences between myoelectric and body-powered upper limb prostheses. This review included 31 publications from 1993-2013 and suggests many of the same benefits of the provision of a myoelectric prosthesis including empirical evidence statements that activity-specific prostheses like a myoelectric device can be more appropriate for a patient. Other evidentiary information included improved cosmesis, psychosocial and social adaptation with the use of a myoelectric terminal device (8). These review studies and clinical practice guidelines show effectiveness, while the FDA has deemed the device as safe. In addition, a more recent study in 2023 examining the EMG feedback from a myoelectric prosthesis suggests improved grasping in various tasks (9). More specifically, multi-articulating hands have been shown to be useful and effective. One recent study by MacEachen et al., 2023, investigated 20 individuals with transradial amputation and the use of a multi-articulating hand. The results suggested improvements in SHAP, TAPES, and Box and Block tests (10). Another study investigating direct control and pattern recognition in myoelectric controls found similar results for home use. However, the authors suggest pattern recognition was more intuitive in choosing specific grips for a task (11). In

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		summary, coverage of myoelectric controls and componentry are essential for achieving appropriate outcomes for qualified beneficiaries with upper limb prosthetic needs. References 1. American Medical Association. (2023). Definitions of â€œScreeningâ€ and â€œMedical Necessityâ€ H-320.953. https://policysearch.ama-assn.org/policyfinder/detail/H-320.953?uri=%2FAMADoc%2FHOD.xml-0-2625.xml 2. FernÃ¡ndez, A., Isusi, I., & GÃ³mez, M. (2000). Factors conditioning the return to work of upper limb amputees in Asturias, Spain. Prosthetics and orthotics international, 24(2), 143â€“147. https://doi.org/10.1080/03093640008726537 3. Malone, J. M., Fleming, L. L., Roberson, J., Whitesides, T. E., Leal, J. M., Poole, J. U., & Grodin, R. S. (1984). Immediate, early, and late postsurgical management of upper-limb amputation.â€¯Journal of Rehabilitation Research and Development,â€¯21(1), 33â€“41. 4. United States Government Accountability Office. (2024). Limb loss: Rehabilitation services and outcomes for Medicare beneficiaries (GAO-25-106406). https://files.gao.gov/reports/GAO-25-106406/index.html 5. Hayes, Inc. (n.d.). Evidence Solutions. https://www.hayesinc.com/hayes-now-a-part-of-symplr/evidence-solutions/ 6. Oâ€™Brien, E., Stevens, P.M., Mandacina, S., Jackman, C. 2021. Journal of Rehabilitation and Assistive Technologies Engineering 8: 1-8 7. Department of Veterans Affairs, and Department of Defense. 2014. VA/DoD Clinical Practice Guideline for the Management of Upper Extremity Amputation Rehabilitation. https://www.healthquality.va.gov/guidelines/Rehab/UEAR/VADoDCPGManagementofUEAR121614Corrected508.pdf 8. Carey, S. L., Lura, D. J., & Highsmith, M. J. (2015). Differences in myoelectric and body-powered upper-limb prostheses: Systematic literature review. Journal of Rehabilitation Research and Development, 52(3), 247-262. https://doi.org/10.1682/JRRD.2014.08.0192 9. Tchimino, J., Dideriksen, J. L., & Dosen, S. (2023). EMG feedback improves grasping of compliant objects using a myoelectric prosthesis. Journal of NeuroEngineering and Rehabilitation, 20(119). https://doi.org/10.1186/s12984-023-01237-1

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		10. MacEachen, V.B., Davie-Smith, F., Carse, B. 2023. Prosthetics and Orthotics International 47(2): 124-129. 11. Simon, A.M., Turner, K.L., Miller, L.A. Hargrove, L.J., Kuiken, T.A. 2019. Institute of Electrical and Electronics Engineers 16th Internation Conference. DOI: 10.1109/ICORR.2019.8779539

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Date	Item Number and Policy	My question/comment
4/10/2025 10:57	2025-HUM-1661-Molecular Diagnostic Assays and Breath Testing...	To whom it may concern, I am an ABIM board certified transplant nephrologist. I obtained my medical degree at the University of Colorado in 2000, completed an Internal Medicine residency also at the University of Colorado in 2003 and subsequently Nephrology and Transplant fellowships at Vanderbilt University in 2007. I have had the privilege of providing medical care for patients with kidney disease and kidney transplant recipients for over 17 years prior to joining CareDx in 2024. On behalf of CareDx, I am writing this letter to comment on the recent Molecular Diagnostic Assays and Breath Testing for Transplant Rejection by Humana / Louisiana Medicaid Medical Coverage Policy. I note that donor-derived cell-free DNA (dd-cfDNA) was considered â€œexperimental / investigational as they are not identified as widely used and general accepted for the proposed uses as reported in nationally recognized peer-reviewed medical literature published in the English languageâ€. While I appreciate the detailed review of the subject, I respectfully note several significant omissions. This letter will focus on literature supporting the coverage of AlloSure Kidney. AlloSure Kidney is an advanced, non-invasive dd-cfDNA assay performed by CareDx exclusively in its Brisbane, CA laboratory for the early detection of graft injury. AlloSure Kidney quantifies the fraction of dd-cfDNA in plasma from kidney transplant recipients using single-nucleotide polymorphisms (SNPs) to accurately differentiate between the genomes of the donor and recipient without requiring separate genotyping or testing of both individuals. This assay has been covered by Medicare since late 2017 through the MolDx Tech Assessment program. A pivotal study published in Nature Medicine (Aubert et al., 2024) demonstrated the clinical validity and utility of dd-cfDNA testing in kidney transplant recipients. This large, prospective, multicenter study evaluated 2,882 transplant recipients from 14 centers across the United States and Europe, including both adult and pediatric patients, making it the most comprehensive dd-cfDNA investigation to date. The cohort included 3,732 biopsies paired with dd-cfDNA samples drawn within 30 days, providing a robust phenotyped dataset. Elevated dd-cfDNA levels were significantly associated with biopsy-confirmed allograft rejection (odds ratio 2.275; 95% CI: 1.902â€“2.739; P < 0.0001), including both antibody-mediated rejection (ABMR) and T cell-mediated rejection (TCMR) (P < 0.0001 for each). Importantly, dd-cfDNA levels were also correlated with Banff 2019 histological rejection severity scores, confirming that this marker reflects both the presence and extent of immune injury. The

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		incorporation of dd-cfDNA into standard-of-care (SOC) surveillance models improved diagnostic performance; the area under the ROC curve (AUC) rose from 0.777 to 0.821 in the derivation cohort (P = 0.0011). These findings were independently validated in the external cohort, where the AUC improved from 0.743 to 0.818, reinforcing reproducibility across different centers and patient populations, including pediatric recipients and 439 African American patients. In the UpToDate: Kidney transplantation in adults: Clinical features and diagnosis of acute kidney allograft rejection (Accessed October 2024), dd-cfDNA is included one of the laboratory assays to identify patients with acute rejection in the â€œWhen to suspect rejectionâ€ section. Included in the â€œSummary and Recommendationsâ€ section, the authors note plasma levels of dd-cfDNA > 1 percent or serially increasing levels are associated with acute rejection. The American Society of Transplant Surgeons published a white paper on dd-cfDNA which was updated in October 2024. The authors report that there is sufficient data the supports the clinical utility of dd-cfDNA in kidney transplant recipients in both the surveillance and for-cause settings. In the â€œSociety Recommendationsâ€ section, they state: We suggest that clinicians consider measuring serial dd-cfDNA levels in kidney transplant recipients with stable renal allograft function to exclude the presence of subclinical antibody mediated rejection. We recommend that clinicians measure dd-cfDNA levels in kidney transplant recipients with acute allograft dysfunction to exclude the presence of rejection, particularly antibody-mediated rejection (ABMR). In summary dd-cfDNA (AlloSure Kidney) is an analytically validated non-invasive test that provides information about the rejection status in kidney transplant recipients. Timely detection of allograft rejection is associated with improved graft survival, and even subclinical rejection has an important impact on graft survival. In addition dd-cfDNA have been shown to provide meaningful information to assist clinicians in the management of immunosuppression in kidney transplant recipients.

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		I would appreciate an opportunity to review these publications with you, ideally in person, so we can discuss any ongoing concerns and collaborate on how we can ensure appropriate use of these expensive but critical tests. Thank you for your attention to this important matter and for your commitment to improving care for kidney transplant recipients in Louisiana. Sincerely, Peale Chuang, MD, FASN Kidney Transplant Medical Director, CareDx
4/10/2025 8:53	2025-HUM-1661-Molecular Diagnostic Assays and Breath Testing...	With respect to AlloMap, the proposed policy covers our testing perfectly. Please approve as proposed. With respect to AlloSure/dd-cfDNA, your policy also considers it experimental and without established clinical value. However, several important references were omitted from your detailed review. Henricksen et al., published their experience from Stanford, a large volume/excellent outcome cardiac transplant center, and demonstrated clear utility in dramatically reducing biopsies when AlloSure Heart was added to AlloMap surveillance. Outcomes remained excellent. Furthermore, Khush et al., in their recent landmark SHORE publication, from 52 centers, 2072 patients and 6363 tests paired with biopsies, demonstrated the clinical validity of AlloMap and AlloSure in detecting rejection and their clinical utility in influencing the decision to proceed with endomyocardial biopsies. Ultimately, the study demonstrated fewer biopsies compared to standard of care with preserved excellent outcomes. Finally, the 2023 ISHLT guidelines for the care of heart transplant recipients, recommended that dd-cfDNA could be considered part of

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		the routine ambulatory follow-up of heart transplant recipients. We have previously submitted the two omitted AlloSure studies. Professional societies such as the International Society for Heart and Lung Transplantation, the American Society of Transplant Surgeons, and the American Society of Transplantation have all issued position statements supporting the use of GEP and cf-DNA in heart transplant patients. These endorsements underscore the consensus within the medical community regarding the clinical utility of these diagnostic tools.
4/9/2025 12:22	2025-UHC-580-Embolization Ovarian Iliac Pelvic Congestion Syndrome	Just testing to see if this works as the comment for my topic wouldn't submit.
4/8/2025 8:35	2025-LHCC-2614-Leveling of ER Services	Coming from a Case Manager/UR nurse I feel this is not a good idea. LHCC will downgrade every submission for approval and the facilities will have to "fight" for payment. The healthcare system is already overburdened with this type of issues due to the MCR/HMO's. It will cause more burdens and I feel will take away from the main concern and this is for the patients we serve.
4/7/2025 16:00	2025-LHCC-1507- Clinical Validation of Modifier 59	The link to the modifier 59 policy brings up the modifier 25 policy so providers cannot review.
4/7/2025 15:56	2025-UHC-222-Skin and Soft Tissue Substitutes	This UHC policy is a sham!!! It doesn't even include diabetic ulcers... IT links to another UHC Policy Number: CS250LA. Skin Substitutes for Chronic Diabetic Lower Extremity Ulcers (for Louisiana ONLY) Effective Date: January 1, 2025... this policy is unlawfully restrictive as it only list 7 products from 4 manufacturers.... There are literally 200+ products in this category to treat Louisiana Medicaid diabetic ulcer patients. This policy misleads providers to think that there are only 7 options... In fact GRAFIX Q4133 has the highest level of supportive evidence in treating lower extremity diabetic ulcers... why it is it not listed? Bottom Line UHC needs to add GRAFIX and other products with evidence to support positive patient outcomes.....

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4/4/2025 18:05	2025-LHCC-1507- Clinical Validation of Modifier 59	The current policy linked to 2025-LHCC-1507 Clinical Validation of Modifier 59 is incorrect and instead shows the Clinical Validation of Modifier 25. This needs to be updated so providers can review the correct policy and raise any concerns through a public comment. 2025-LHCC-1507 Link referencing Validation Modifier 25 and does not mention Validation of Modifier 59 as the title states: https://ldh.la.gov/assets/Medicaid/MCPP/3_27_25/1507_LHCC_LA.PP.013_Clinical_Validation_of_Modifier_25.pdf
4/4/2025 16:33	2025-LHCC-2613-30 Day Readmission	In August 2018, LHC retracted its 30-day readmission policy, and letters from the Medicaid Director in 2019 confirmed that the policy was implemented in violation of the contract between LDH and LHC. In the letter to LHC, the Medicaid Director stated, "The Louisiana Medicaid fee-for-service program has no policy or practice of denying payment or reimbursement for hospital admissions." According to the MCO Manual, 42 C.F.R. Â§ 438.210 mandates that MCOs provide coverage for services that is no more restrictive than Medicaid FFS. Therefore, this policy should not be allowed to be implemented, as the coverage requirements remain consistent, and LDH has not indicated that this practice is allowed in either the Hospital Services Provider Manual or the MCO Manual. Providers already struggle with MCOs regarding approving the full inpatient stay due to legitimate delays in discharge, and the plans have historically not been proactive in coordinating placement of the patient. We are concerned that this policy in conjunction with these issues would not result in safe or appropriate discharges for Louisiana Medicaidâ€™s patient population. 2019 Letter to LHC: https://ldh.la.gov/assets/docs/BayouHealth/Accountability/2.0/LHC/LHC_Notice_of_Action_Readmission_Policy_10.12.18.pdf 2019 Letter to Mr. Keith Benner: https://ldh.la.gov/assets/docs/BayouHealth/Accountability/2.0/LHC/LHCC_ReAdmission_Appeal_Denial_Ltr.pdf LHC Retraction of Policy in 2018: https://www.louisianahealthconnect.com/newsroom/2018-42--30-day-readmission-policy.html

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4/4/2025 16:20	2025-LHCC-2614-Leveling of ER Services	Our organization has significant concerns regarding the potential implementation of this policy. If it proceeds and is adopted by other managed care organizations, it may result in inconsistencies in the reimbursement process for Louisiana Medicaid patient claims across the six MCOs as well as Traditional Medicaid. These discrepancies could create confusion and administrative burdens for healthcare providers as it would be impossible for providers to code according to the individual plansâ€™ policies, especially when CMS mandates that a consistent coding guideline be followed for facility ER claims. The cost that would be associated with appealing these underpayments would also impact both the provider and the MCO - providers can already experience lengthy delays waiting for reconsiderations and appeals to be processed and this would only further accentuate the issue. We urge careful consideration of these potential consequences before moving forward with the policy.
4/3/2025 11:50	2025-LHCC-2613-30 Day Readmission	1. A readmission policy that does not account for ALL the factors influencing a readmission is often unfair and particularly punitive. 2. Some of these patient factors may be more pronounced in the Medicaid population, such as poor health literacy, non-compliance, limited access to follow-up, lack of resources and home support, and resistance to end of life measures. 3. A readmission policy that is more stringent than that outlined by CMS (that is, a policy that penalizes the facility on a case by case basis and not the overall incidence of readmissions related to a benchmark), does not provide accurate or sufficient reimbursement for the care given to the Medicaid population. 4. According to the MCO Manual, 42 C.F.R. 438.210 mandates that MCOs provide coverage for services that is no more restrictive than Medicaid-Fee-For-Service. 5. We face challenges now on a daily basis with the MCOs downgrading the patient's stay to Observation, reducing the approval of additional days of care and not difficulty in providing post acute services to the Medicaid population. Without the ability to provide those resources on the post acute side, whether home health or Skilled Nursing etc, the patients are bound to bounce back, no fault of the hospital.
4/3/2025 11:40	2025-LHCC-2614-Leveling of ER Services	1. The first flaw in the logic is that they use the discharge diagnosis in the algorithm. This does not consider those patients whose presentation appears more serious. These patients require a more intense workup and more resources. EX: a. A chest pain patient who ends up having a GI issue b. A trauma patient who comes in via ambulance, but it turns out injuries are minor. 2. To downgrade 2 levels (to level 3) for a case originally billed as a level 5 is egregious and does not account for the resources used in these cases. 3. Often, a facilityâ€™s certifications (chest pain, trauma, etc.) do require more thorough testing when patientsâ€™ presentations warrant the use of the protocols

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		associated with these certifications. 4. Downgrading ED codes after the fact creates a new layer of administrative burden, appeals and means a lot more administrative resources to track down denials and fight the downgrades. These accounts are coded using National guidelines which provide a consistent appropriate of coding based upon resources utilized,
4/2/2025 15:49	2025-HBL-951-Durable Medical Equipment	Why aren't CROW walkers (L4631) covered for Medicaid patients as this is the last preventative AFO used for lower extremity amputations?
4/2/2025 11:20	2025-LHCC-2614-Leveling of ER Services	- Inappropriateness of allowing Medicaid MCOs to downcode or change the nature of a claim or its state plan specified reimbursement: The appropriateness of an ED visit is not always supported by the patients final diagnosis. Most patients are not medical

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3/28/2025 18:42	2025-UHC-1873- Lower Extremity Prosthetics	Medically Necessary The proposed updates noted in 2025-UHC-1873 and 2025-UHC-1849 include the elimination of the current definition of "medically necessary," which could have serious negative consequences on both patients and insurance companies. We suggest adopting the â€œmedically necessaryâ€ definition put forth by the American Medical Association (AMA) (1). For patients, the lack of clarity on what is medically necessary can lead to delays or denials of essential treatments resulting in worsening health conditions, increased suffering, and potentially life-threatening events. Patients who are not fitted with a prosthesis after an amputation have a higher mortality rate than those who are fitted with a prosthesis (2). Adults who are not fitted with a prosthesis within a year of their amputation are twice as likely to visit the emergency department compared to those who receive a prosthesis within three months (3), which leads to higher healthcare utilization for these individuals and increases costs for payors, individuals, and taxpayers. Patients may also face significant financial burdens if they are forced to pay out-of-pocket. Furthermore, although only 8% of Medicare beneficiaries are black, they account for a disproportionate 21% of those who have experienced limb loss (4). Additionally, rural Black patients faced an increase of over 10% in the risk of major leg amputation or death (5). By adopting the AMA definition of â€œmedically necessaryâ€, UHC can help address these inequalities by ensuring equitable access to necessary services. K2 coverage for MPKs There is ample evidence to suggest MPKs for K2 ambulators improve health benefits such as reducing the number of falls (6-13), decreasing fall risk (6,9,10,12,14-16), and lessening the burden of fear of falling (8,9,12,17,18). Approximately 25% of individuals aged 65 and older fall at least once per year, and nearly 20% of falls in all individuals lead to either broken bones or a head injury (19). According to the Centers for Disease Control and Prevention (CDC), millions of people are treated in emergency departments annually (20), and in 2015, Medicare and Medicaid spent more than $37 billion in medical costs related to falls (21). Lastly, Medicare expanded coverage for microprocessor-controlled prosthetic knees (MPKs) effective September 1, 2024, to include K2-level beneficiaries, allowing for the use of fluid, pneumatic, and electronic/MPK systems when medically necessary. Bone Anchored Percutaneous Limb Prostheses The first study mentioned in relation to osseointegration was a private report by Hayes Inc., that states on their website that they â€œmake it easier for health plans to makeâ€¦ defensible choices for coverage policy, utilization management, and appeals decisions by using our evidence resources and personalized support

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		(27).â€ Without reliance on peer-reviewed evidence, there is increased risk of influence from bias. Osseointegration procedure, when applied to the appropriate patient, can create a viable prosthetic option for individuals that are unable to tolerate a socket-suspended prosthesis. And, while the evidence on osseointegration continues to advance, early potential benefits for the appropriate patient indicate improved mobility, higher return to work, better quality of life, and increased patient satisfaction. UHC policy should consider these benefits and the persistent demand for osseointegration, ensuring that patients are not left without viable prosthetic options. Rigid Dressings It is imperative that rigid dressings be covered by the State of Louisiana Medicaid Program. A literature review of 15 articles highlights that rigid dressings reduce the time from amputation to healing, discharge, and prosthesis fitting, while also decreasing post-amputation edema (29). Additionally, rigid dressings offer benefits beyond residual limb healing. A study conducted at the University of Maryland vascular service from 2016 to 2021 found that the AmpushieldÂ® rigid dressing led to a substantial reduction in narcotic prescriptions (50.5 morphine equivalents vs. 108.9), improved ambulatory status (75.9% vs. 29.3%), and a lower rate of revision to a higher amputation level compared to soft dressings (9.3% vs. 41.5%) (30). Additionally, rigid dressings offer better protection for the prosthetic limb compared to soft dressings and can prevent trauma to the residual limb during falls, with injury rates dropping from 22% to 0% and from 17% to 0% with use of these devices (31-33). References 1. American Medical Association. (2023). Definitions of â€œScreeningâ€ and â€œMedical Necessityâ€ H-320.953. https://policysearch.ama-assn.org/policyfinder/detail/H-320.953?uri=%2FAMADoc%2FHOD.xml-0-2625.xml 2. Singh, R. K., & Prasad, G. (2016). Long-term mortality after lower-limb amputation. Prosthetics and orthotics international, 40(5), 545â€“551. https://doi.org/10.1177/0309364615596067 3. Miller, T. A., Paul, R., Forthofer, M., & Wurdeman, S. R. (2021). The Role of Earlier Receipt of a Lower Limb Prosthesis on Emergency Department Utilization. PM & R : The Journal of Injury, Function, and Rehabilitation, 13(8), 819â€“826. https://doi.org/10.1002/pmrj.12504 4. United States Government Accountability Office. (2024). Limb loss: Rehabilitation services and outcomes for Medicare beneficiaries (GAO-25-106406). https://files.gao.gov/reports/GAO-25-106406/index.html 5. Brennan, M. B., Powell, W. R., Kaiksow, F., Kramer, J., Liu, Y., Kind, A. J. H., & Bartels, C. M. (2022). Association of Race, Ethnicity, and Rurality With Major Leg

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		Amputation or Death Among Medicare Beneficiaries Hospitalized With Diabetic Foot Ulcers. JAMA Network Open, 5(4). https://doi.org/10.1001/jamanetworkopen.2022.8399 6. Burnfield, J.M., et al., Impact of stance phase microprocessor-controlled knee prosthesis on ramp negotiation and community walking function in K2 level transfemoral amputees. Prosthet Orthot Int, 2012. 36(1): p. 95-104. 7. Davie-Smith, F. and B. Carse, Comparison of patient-reported and functional outcomes following transition from mechanical to microprocessor knee in the low-activity user with a unilateral transfemoral amputation. Prosthet Orthot Int, 2021. 45(3): p. 198-204. 8. Hafner, B.J. and D.G. Smith, Differences in function and safety between Medicare Functional Classification Level-2 and -3 transfemoral amputees and influence of prosthetic knee joint control. J Rehabil Res Dev, 2009. 46(3): p. 417-33. 9. Hahn, A., S. Bueschges, M. Prager, and A. Kannenberg, The effect of microprocessor controlled exo-prosthetic knees on limited community ambulators: systematic review and meta-analysis. Disabil Rehabil, 2022. 44(24): p. 7349-7367. 10. Kannenberg, A., B. Zacharias, and E. Probsting, Benefits of microprocessor-controlled prosthetic knees to limited community ambulators: systematic review. J Rehabil Res Dev, 2014. 51(10): p. 1469-96. 11. Kaufman, K.R., K.A. Bernhardt, and K. Symms, Functional assessment and satisfaction of transfemoral amputees with low mobility (FASTK2): A clinical trial of microprocessor-controlled vs. non-microprocessor-controlled knees. Clin Biomech (Bristol, Avon), 2018. 58: p. 116-122. 12. Wong, C.K., J. Rheinstein, and M.A. Stern, Benefits for Adults with Transfemoral Amputations and Peripheral Artery Disease Using Microprocessor Compared with Nonmicroprocessor Prosthetic Knees. Am J Phys Med Rehabil, 2015. 94(10): p. 804-10. 13. Wurdeman, S.R., T.A. Miller, P.M. Stevens, and J.H. Campbell, Stability and Falls Evaluations in AMPutees (SAFE-AMP 1): Microprocessor knee technology reduces odds of incurring an injurious fall for individuals with diabetic/dysvascular amputation. Assist Technol, 2023. 35(3): p. 205-210. 14. Kahle, J.T., M.J. Highsmith, and S.L. Hubbard, Comparison of nonmicroprocessor knee mechanism versus C-Leg on Prosthesis Evaluation Questionnaire, stumbles, falls, walking tests, stair descent, and knee preference. J Rehabil Res Dev, 2008. 45(1): p. 1-14. 15. Lansade, C., et al., Mobility and satisfaction with a microprocessor-controlled knee in moderately active amputees: A multi-centric randomized crossover trial. Ann Phys Rehabil Med, 2018. 61(5): p. 278-285.

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		16. Wurdeman, S.R., P.M. Stevens, and J.H. Campbell, Mobility analysis of amputees (MAAT 3): Matching individuals based on comorbid health reveals improved function for above-knee prosthesis users with microprocessor knee technology. Assist Technol, 2020. 32(5): p. 236-242. 17. Jayaraman, C., et al., Using a microprocessor knee (C-Leg) with appropriate foot transitioned individuals with dysvascular transfemoral amputations to higher performance levels: a longitudinal randomized clinical trial. J Neuroeng Rehabil, 2021. 18(1): p. 88. 18. Mileusnic, M.P., A. Hahn, and S. Reiter, Effects of a Novel Microprocessor-Controlled Knee, Kenevo, on the Safety, Mobility, and Satisfaction of Lower-Activity Patients with Transfemoral Amputation. American Academy of Orthotists and Prosthetists, 2017. 29(4): p. 198-205. 19. Bergen G, Stevens MR, Burns ER. Falls and Fall Injuries Among Adults Aged â‰¥65 Years â€" United States, 2014. MMWR Morb Mortal Wkly Rep 2016;65:993â€“998. DOI: http://dx.doi.org/10.15585/mmwr.mm6537a2 20. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Webâ€“based Injury Statistics Query and Reporting System (WISQARS) [online]. https://www.cdc.gov/falls/facts.html 21. Florence CS, Bergen G, Atherly A, Burns ER, Stevens JA, Drake C. Medical Costs of Fatal and Nonfatal Falls in Older Adults. Journal of the American Geriatrics Society, 2018 March, DOI:10.1111/jgs.15304 22. Hafner BJ, Smith DG. Differences in function and safety between Medicare Functional Classification Level-2 and -3 transfemoral amputees and influence of prosthetic knee joint control. J Rehabil Res Dev. 2009;46(3):417-33. PMID: 19675993. 23. Miller WC, Deathe AB, Speechley M, Koval J. The influence of falling, fear of falling, and balance confidence on prosthetic mobility and social activity among individuals with a lower extremity amputation. Arch Phys Med Rehabil. 2001 Sep;82(9):1238-44. doi: 10.1053/apmr.2001.25079. PMID: 11552197. 24. Mundell B, Maradit Kremers H, Visscher S, Hoppe K, Kaufman K. Direct medical costs of accidental falls for adults with transfemoral amputations. Prosthet Orthot Int. 2017 Dec;41(6):564-570. doi: 10.1177/0309364617704804. Epub 2017 Jun 22. PMID: 28641476. 25. Wurdeman, S. R., Miller, T. A., Stevens, P. M., & Campbell, J. H. (2023). Stability and Falls Evaluations in AMPutees (SAFE-AMP 1): Microprocessor knee technology reduces odds of incurring an injurious fall for individuals with diabetic/dysvascular amputation. Assistive technology : the official journal of RESNA, 35(3), 205â€“210. https://doi.org/10.1080/10400435.2021.2010147

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		26. Kahle JT, Highsmith MJ, Hubbard SL. Comparison of nonmicroprocessor knee mechanism versus C-Leg on Prosthesis Evaluation Questionnaire, stumbles, falls, walking tests, stair descent, and knee preference. J Rehabil Res Dev. 2008;45(1):1-14. doi: 10.1682/jrrd.2007.04.0054. PMID: 18566922. 27. Hayes, Inc. (n.d.). Evidence Solutions. https://www.hayesinc.com/hayes-now-a-part-of-symplr/evidence-solutions/ 28. U.S. Food and Drug Administration. (2020, December 18). FDA approves prosthetic implant for above-the-knee amputations. Retrieved March 27, 2025, from https://www.fda.gov/news-events/press-announcements/fda-approves-prosthetic-implant-above-knee-amputations 29. Reichmann, J. P., Stevens, P. M., Rheinstein, J., & Kreulen, C. D. (2018). Removable Rigid Dressings for Postoperative Management of Transtibial Amputations: A Review of Published Evidence. PM & R : The Journal of Injury, Function, and Rehabilitation, 10(5), 516â€“523. https://doi.org/10.1016/j.pmrj.2017.10.002 30. Sarkar, A., Fencel, R., Dunlap, E., Fitzpatrick, S., & Nagarsheth, K. (2023). Utility of removable rigid dressings in decreasing discharge narcotic use and improving ambulation following below-knee amputation. Annals of Vascular Surgery, 91, 242â€“248. https://doi.org/10.1016/j.avsg.2022.11.003 31. Deutsch, A., English, R. D., Vermeer, T. C., Murray, P. S., & Condous, M. (2005). Removable rigid dressings versus soft dressings: A randomized, controlled study with dysvascular, trans-tibial amputees. Prosthetics and Orthotics International, 29(2), 193â€“200. 32. Hughes, S., Ni, S., & Wilson, S. (1998). Use of removable rigid dressing for transtibial amputees rehabilitation: A Greenwich Hospital experience. Australian Journal of Physiotherapy, 44(2), 135â€“137. https://doi.org/10.1016/S0004-9514(14)60374-3 33. Gooday, H. & Hunter, J. (2004.). Preventing falls and stump injuries in lower limb amputees during inpatient rehabilitation: completion of the audit cycle. Clinical Rehabilitation, 18(4), 379â€“390. https://doi.org/10.1191/0269215504cr738oa

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Date	Item Number and Policy	My question/comment
3/28/2025 16:59	2025-UHC-1851-Whole Exome and Whole Genome Sequencing	Thank you for the opportunity to ask questions regarding managed care policies and procedures. We have a question regarding submitting requests covered by a biomarker bill that may or may not be covered by this policy: In our experience with other states when testing is covered under a biomarker bill, there is not a clear pathway to submit requests to Medicaid FFS or MCOs. How would we submit requests for outpatient exome sequencing (81415, 81416) and outpatient genome sequencing (81425, 81426) which would fall under Louisiana Bill S.B. 104 (https://www.legis.la.gov/legis/ViewDocument.aspx?d=1332542)? (The bill states that the â€œindividual and the healthcare provider shall have access to a clear, readily accessible, and convenient process to request an exception to a coverage policy or adverse utilization review determination of a health coverage plan.â€) Louisiana S.B. 104 explicitly states biomarker testing includes both exome sequencing (ES) and genome sequencing (GS) and coverage is â€œfor the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of an individualâ€™s disease or condition when the test provides clinical utility as demonstrated byâ€¦.nationally recognized clinical practice guidelines.â€ The 2021 American College of Medical Genetics and Genomics (ACMG) evidence-based practice guideline strongly recommend ES and GS for patients with congenital anomalies, developmental delay, and/or intellectual disability.1 The 2022 National Society of Genetic Counselors (NSGC) evidence-based guideline strongly recommends ES and GS for individuals with unexplained epilepsy regardless of age. This guideline was endorsed by the American Epilepsy Society (AES).2 The ACMG and NSGC/AES clinical guidelines do not distinguish between ES and GS in their recommendations, citing impact on personalized treatment strategies offered by both tests.

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		Both guidelines cite clinical literature demonstrating comparable clinical utility and impact on the active and long-term management of patients with suspected genetic disorders between ES and GS. The clinical utility of ES and GS is well-established across various medical specialties, including genetics, maternal-fetal medicine, neurology, and developmental pediatrics. A total of 32 state Medicaids cover ES and/or GS in the outpatient setting 1Manickam K, McClain MR, Demmer LA, et al. Exome and genome sequencing for pediatric patients with congenital anomalies or intellectual disability: an evidence-based clinical guideline of the American College of Medical Genetics and Genomics (ACMG). Genet Med. Nov 2021;23(11):2029-2037. doi:10.1038/s41436-021-01242-6 2Smith L, Malinowski J, Ceulemans S, et al. Genetic testing and counseling for the unexplained epilepsies: An evidence-based practice guideline of the National Society of Genetic Counselors. J Genet Couns. Oct 24 2022;doi:10.1002/jgc4.1646

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Date	Item Number and Policy	My question/comment
3/28/2025 15:14	2025-UHC-1873- Lower Extremity Prosthetics	I appreciate the opportunity to provide input on the proposed Lower Extremity Prosthetic policies. As a third-generation practitioner of our 114-year-old company, I have several areas of concern. Osseointegration as a newly developing area of care requires an integrated team approach and coordinated professional care from several disciplines. Protocols and standards of care need to be developed before future coverage is considered. The most concerning omission is that of medical necessity. This change removes the professionals who are closest to the functional and medical needs of the patient to become one that is removed and made solely on an administrative basis. Micro processor knees can be utilized in function level K2 or higher in some cases for stumble recovery, and added stability that meet the current Medicare coverage criteria factoring in both the medical and functional level requirements. Respectfully submitted. W. Clint Snell, CPO Snells Limbs and Braces Please review the draft comment to the proposed Medicaid Lower Extremity Prosthetic policy. Is the personal information in the first paragraph a plus? Please send any recommendations to me. Thanks Clint Sent from my iPhoneL
3/25/2025 8:05	2025-UHC-1873- Lower Extremity Prosthetics	Is the public comment viewable?

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Date	Item Number and Policy	My question/comment
3/20/2025 14:35	2025-UHC-1873- Lower Extremity Prosthetics	Microprocessor-controlled knees (MPKs) offer significant benefits, particularly for users with a lower activity level. These advanced devices feature vital functions like stumble recovery and variable flexion resistance, providing enhanced stability and support for individuals who may not be as physically active. MPKs allow users to recover from potential falls, if the knee isn't fully extended before the prosthetic is weighted, reducing the risk of injury. In contrast, non-MPK knees lack these adaptive features, leaving users more vulnerable to falls when a misstep occurs. This can lead to serious injuries and escalate medical costs. By incorporating MPKs, lower activity users gain an added layer of protection, improving safety, reducing the risk of further injury, and ultimately lowering long-term healthcare expenses.
3/20/2025 14:26	2025-UHC-1849-Upper Extremity Myoelectric Prosthetic Devices	Myoelectric controls for prosthetic devices offer a significant improvement over traditional body-powered options, providing users with greater precision and effortless control of their terminal devices. These advanced systems are not only easier to don, but they also offer a more aesthetically pleasing appearance, which boosts both confidence and satisfaction. With enhanced comfort and functionality, myoelectric prosthetics encourage higher user compliance, leading to increased independence, improved quality of life, and better overall health. This heightened autonomy not only fosters personal well-being but also helps to reduce long-term medical costs, making myoelectric prosthetics a smart and transformative choice.
3/19/2025 13:30	2025-UHC-1873- Lower Extremity Prosthetics	The current Medicaid reimbursement rate on lower extremity prosthesis (approximately 57% of Medicare allowable) just isn't feasible any longer. I honestly cannot even remember the last time there has been an increase in the Medicaid fee schedule, but know that it's been several years at the least. The cost of materials, components, labor, etc. has risen exponentially in the last few years and Medicaid must adjust their fee schedule in order to account for that rise in cost. Otherwise, there is no profit available, or in some cases, the company takes a loss when providing lower extremity prosthesis to Medicaid beneficiaries.

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3/18/2025 13:20	2025-UHC-1849-Upper Extremity Myoelectric Prosthetic Devices	The major challenge with our profession is, we do not charge an office visit fee like most health care providers. Physicians, therapist, etc. can charge for their time. We do not! Prosthetics is the branch of medicine that deals with evaluating, designing, fabricating, fitting and delivering a prosthesis or artificial limb to replace what is missing.Â Orthotics involves bracing an existing part of the body. â€œOrthosesâ€ are the devices a person wears to enhance function and/or reduce or eliminate pain. The education, training, knowledge, and skill to become a Certified Prosthetist / Orthotist (CPO) requires a Masterâ€™s Degree with a 2 year residency and successfully passing of 6 national board exams. CPOâ€™s are not â€œvendors of suppliesâ€, however, they are providers of high level medical treatments. Since the evaluating, designing, fabricating, fitting, delivering, and follow ups are all included in one date of service (DOS), our one-time payment per case is heavily scrutinized. A lot of fixed and variable expenses are included in that one-time payment from Medicaid. The reality is that everything has increased in cost per this current economic climate. Our cost of goods sold (COGS) has increased 3%-15% on average since 2021. This doesnâ€™t include increases in professional salaries, office expenses, liability insurance premiums that have tripled, and the extra expenses incurred over the past few years providing quick turnaround to your members.

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		In conclusion, we have worked extremely hard as a second generation company since 1984 to fulfill our obligation providing professional and high level service to your clients. We will continue to do this, however, a fair compensation is paramount. The current fee for service is unrealistic when everything has increased! Ultimately, I want whatâ€™s best for my clients and so should you. Michael S. Relle, CPO/FAAOP Certified Prosthetist/Orthotist, Fellow Past President of the Louisiana Association of Orthotists and Prosthetists, (LAOP)

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Date	Item Number and Policy	My question/comment
3/18/2025 13:14	2025-UHC-1873- Lower Extremity Prosthetics	The major challenge with our profession is, we do not charge an office visit fee like most health care providers. Physicians, therapist, etc. can charge for their time. We do not! Prosthetics is the branch of medicine that deals with evaluating, designing, fabricating, fitting and delivering a prosthesis or artificial limb to replace what is missing.Â Orthotics involves bracing an existing part of the body. â€œOrthosesâ€ are the devices a person wears to enhance function and/or reduce or eliminate pain. The education, training, knowledge, and skill to become a Certified Prosthetist / Orthotist (CPO) requires a Masterâ€™s Degree with a 2 year residency and successfully passing of 6 national board exams. CPOâ€™s are not â€œvendors of suppliesâ€, however, they are providers of high level medical treatments. Since the evaluating, designing, fabricating, fitting, delivering, and follow ups are all included in one date of service (DOS), our one-time payment per case is heavily scrutinized. A lot of fixed and variable expenses are included in that one-time payment from Medicaid. The reality is that everything has increased in cost per this current economic climate. Our cost of goods sold (COGS) has increased 3%-15% on average since 2021. This doesnâ€™t include increases in professional salaries, office expenses, liability insurance premiums that have tripled, and the extra expenses incurred over the past few years providing quick turnaround to your members.

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3/18/2025 9:37	2025-UHC-1849-Upper Extremity Myoelectric Prosthetic Devices	We need a fee schedule increase to continue providing care to Medicaid patients.
3/18/2025 9:36	2025-UHC-1873- Lower Extremity Prosthetics	We need a fee schedule increase to continue providing care to Medicaid patients.
3/18/2025 9:29	2025-UHC-1849-Upper Extremity Myoelectric Prosthetic Devices	The current Medicaid fee schedule is causing a reduction in components that are available for use which can lead to hindered progress for the patient. Patient care is being limited by the stringent red tape and the lack of funds. The quicker we restore a patientâ€™s function the faster they can get back to work and continue on with a semblance of normality in life. The practice of medicine is becoming the business of medicine being controlled by a profit only perspective and this is a sickening approach to healthcare.
3/18/2025 9:04	2025-UHC-1873- Lower Extremity Prosthetics	With the current Medicaid fee schedule, it is difficult for my patients to receive proper early intervention care and the components that are available to them at this price point are not meeting their basic activity needs for daily living and hindering their progress in mobility improvement.

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3/18/2025 8:36	2025-UHC-1849-Upper Extremity Myoelectric Prosthetic Devices	This increase in Medicaid reimbursement is crucial to allowing the providers to continue to support the population that requires these devices to maintain the ability to function with 2 arms. Without it these providers will have to limit the # of people they can take that has Medicaid or will have to discontinue servicing this population all together.
3/18/2025 8:35	2025-UHC-1873- Lower Extremity Prosthetics	This increase in Medicaid reimbursement is crucial to allowing the providers to continue to support the population that requires these devices to maintain mobility. Without it these providers will have to limit the # of people they can take that has Medicaid or will have to discontinue servicing this population all together.
3/18/2025 8:30	2025-UHC-1873- Lower Extremity Prosthetics	Prosthetics needs to increase reimbursement rates for prosthetics/orthotics to continue to be able to provide care for all Louisianians.
3/18/2025 8:16	2025-UHC-1873- Lower Extremity Prosthetics	There are complications with normal amputations that require additional intervention but I don't believe that means a patient can't be capable of using that type of prosthesis effectively I believe a K2 has more than enough potential to excel with a microprocessor foot/ ankle compared to a K1
3/18/2025 7:48	2025-UHC-1873- Lower Extremity Prosthetics	With todayâ€™s Medicaids fee schedule, one barely breaks even from the cost of goods it takes to make a Prosthetic device.
3/17/2025 21:54	2025-UHC-1849-Upper Extremity Myoelectric Prosthetic Devices	Medicaid patients should have the same options when it comes to prosthetics that Medicare and other insurance companies have especially when it comes to modern technology
3/17/2025 21:51	2025-UHC-1873- Lower Extremity Prosthetics	In order for patients to get the same level of care there Needs to be a price increase Medicaid pays 57% of Medicares allowable fee schedule on L Codes they recognize
3/17/2025 21:30	2025-UHC-1849-Upper Extremity Myoelectric Prosthetic Devices	Myoelectric prosthetics should be considered for provision to Medicaid patients in cases of bilateral amputation, impairment of the non-amputated limb, or inability to operate a cable-driven prosthesis.
3/17/2025 21:26	2025-UHC-1873- Lower Extremity Prosthetics	Current Medicaid reimbursement for prosthetic limbs is 57% of Medicare allowables. This is making provision of prosthetic limbs for this population unaffordable to provide, and it is hurting our industry's ability to keep certified clinicians from leaving Louisiana. High technology is not necessary for the non-working Medicaid population, but increased Medicaid fee schedule rates for non-computerized prosthetics are needed to continue serving these citizens of our state.

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3/10/2025 19:56	2025-LHCC-2612-Multiple ER Visits, Same Day	The current policy linked to 2025-LHCC-2612 Multiple ER Visits Same Day is incorrect and instead shows the Leveling of Emergency Room Services. This needs to be updated so providers can review the correct policy and raise any concerns through a public comment. 2025-LHCC-2612 Link referencing level of ER services and does not mention multiple same day ER visits as the title states: https://ldh.la.gov/assets/medicaid/MCPP/3_10_25/2612_LHCC_LA.PP.053_Leveling_of_ER_Services.pdf
2/14/2025 19:29	2025-HUM-2638- Drugs & Biologicals HCPCS	We are seeking clarification on why pharmacy providers are permitted to bill different units every 6 weeks, while other providers are not. After reviewing the drug label, there is no indication that varying quantities can be administered by different specialties. Additionally, we are unable to find any other insurance plans, including Medicare and Medicaid, that restrict unit billing based on provider specialty.
2/3/2025 15:26	2025-ACLA-2133-Prior Authorization Services List	We would like to formally request that the MCO reconsider the requirement for prior authorization for respiratory viral panels (CPTs 87631, 87632, 87633). According to LDH IB 24-31, these services are deemed medically necessary under specific circumstances. We suggest that ACLA implement a medical necessity edit during claims processing, rather than requiring prior authorization. Our patients are high-risk and in poor health, and it is unreasonable to delay their care while we wait for authorization. LDH Bulletin: https://ldh.la.gov/assets/docs/BayouHealth/Informational_Bulletins/2024/IB24-31.pdf The 87632/87633 Section specifically states: "Beneficiaries with serious or critical illness or at imminent risk of becoming seriously or critically ill, immunodeficiency, and/or severe underlying condition contributory to testing using an expanded syndromic panel."
2/3/2025 15:08	2025-ABH-2604-Unattended Sleep Studies	Could the MCO please clarify why this service is being covered on such a limited basis? Novitas, the CMS MAC for most of Louisiana, has determined that these sleep studies are medically necessary for a range of conditions beyond the six diagnosis codes specified (see LCD Article A56923). It is concerning that ABH offers such restricted coverage compared to other MCOs and the primary Medicare MAC.
2/3/2025 14:41	2025-ABH-2605-Vitamin D Testing	I attempted to access the policy using both Chrome and Edge, but I was unable to open the linked Excel spreadsheet to review the proposed DX codes. This is hindering providers from fully reviewing the information and raising any potential concerns.
2/3/2025 14:39	2025ABH-2606-Gastrointestinal Panel Testing	I attempted to access the policy using both Chrome and Edge, but I was unable to open the linked Excel spreadsheet to review the proposed DX codes. This is hindering providers from fully reviewing the information and raising any potential concerns.

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Date	Item Number and Policy	My question/comment
2/3/2025 14:39	2025-ABH-2607- Diagnostic Mammograms	I attempted to access the policy using both Chrome and Edge, but I was unable to open the linked Excel spreadsheet to review the proposed DX codes. This is hindering providers from fully reviewing the information and raising any potential concerns.
1/13/2025 14:29	2025-LHCC-2613- 30 Day Readmission	In August 2018, LHC retracted its 30-day readmission policy, and letters from the Medicaid Director in 2019 confirmed that the policy was implemented in violation of the contract between LDH and LHC. In the letter to LHC, the Medicaid Director stated, "The Louisiana Medicaid fee-for-service program has no policy or practice of denying payment or reimbursement for hospital admissions." According to the MCO Manual, 42 C.F.R. Â§ 438.210 mandates that MCOs provide coverage for services that is no more restrictive than Medicaid FFS. Therefore, this policy should not be allowed to be implemented, as the coverage requirements remain consistent, and LDH has not indicated that this practice is allowed in either the Hospital Services Provider Manual or the MCO Manual. 2019 Letter to LHC: https://ldh.la.gov/assets/docs/BayouHealth/Accountability/2.0/LHC/LHC_Notice_of_Action_Readmission_Policy_10.12.18.pdf 2019 Letter to Mr. Keith Benner: https://ldh.la.gov/assets/docs/BayouHealth/Accountability/2.0/LHC/LHCC_ReAdmission_Appeal_Denial_Ltr.pdf LHC Retraction of Policy in 2018: https://www.louisianahealthconnect.com/newsroom/2018-42--30-day-readmission-policy.html
1/13/2025 12:49	2025-LHCC-2614- Leveling of ER Services	Our organization has significant concerns regarding the potential implementation of this policy. If it proceeds and is adopted by other managed care organizations, it may result in inconsistencies in the reimbursement process for Louisiana Medicaid patient claims across the six MCOs as well as Traditional Medicaid. These discrepancies could create confusion and administrative burdens for healthcare providers as it would be impossible for providers to code according to the individual plansâ€™ policies, especially when CMS mandates that a consistent coding guideline be followed for facility ER claims. We urge careful consideration of these potential consequences before moving forward with the policy.

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Date	Item Number and Policy	My question/comment
11/18/2024 8:28	2024-HBL-2540- Modifier Usage RP	On behalf of its member hospitals and health systems, the Louisiana Hospital Association appreciates the opportunity to comment on proposed Medicaid MCO policies. The proposed use of claim rejection as a means of enforcing reimbursement policies prior to the acceptance and adjudication of a claim is a growing concern. 42 CFR 447.5 states that a clean claim â€œmeans one that can be processed without obtaining additional information from the provider of the service or from a third party.â€ While seemingly innocuous on the surface, the terms of rejection and acceptance related to the claims process are critically important. Once a claim is accepted through the filing process, there is an expectation of adjudication and a decision of payment or denial. Underpaid or denied claims have very specific contractual and statutory processes through which those decisions can be questioned or disputed. If what would normally be a clean claim is rejected prior to acceptance in the MCO claim system, then there is no adjudicated decision to dispute. Through a rejection mechanic, an MCO could potentially force a provider into adherence to arbitrary rules or processes, thus increasing the administrative burden on the provider while at the same time, reducing their own processing load and artificially manipulating claims processing statistics. We encourage the Department to more closely review proposed MCO policies for this tactic, as well as have a greater understanding what exactly the MCOs may be rejecting on the claim front. As always, if you have any questions or need additional information, please let us know.
11/18/2024 8:26	2024-HBL-2570- Advanced Imaging: Site of Care	On behalf of its member hospitals and health systems, the Louisiana Hospital Association appreciates the opportunity to comment on proposed Medicaid MCO policies. Access to certain services remains a challenge in the Medicaid managed care program. Through this policy, Healthy Blue appears to be restricting access to hospital-based advanced imaging services. We would encourage the Department to have a full understanding of the availability of these services to vulnerable populations through a detailed network adequacy study prior to allowing Healthy Blue to deny medically necessary advanced imaging services.

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Date	Item Number and Policy	My question/comment
10/21/2024 14:44	2024-HUM-2525- Claims Payment Policy	On behalf of its member hospitals and health systems, the Louisiana Hospital Association appreciates the opportunity to provide comment on proposed Humana Medicaid Policy 2024-HUM-2525. The LHA is concerned about this proposed policy for several reasons. First, the proposed policy speaks in terms of â€œMinimum Criteria for Acceptance.â€ 42 CFR 447.45(b) defines a clean claim as â€œâ€¦one that can be processed without obtaining additional information from the provider of the service or from a third party.â€ Humana appears to be creating a scenario where a plan could refuse to â€œacceptâ€ a clean claim, which in our opinion, would be in conflict with federal regulation and the stateâ€™s MCO contract. The proposed policy also appears to replicate an American College of Emergency Physicians â€˜guidelineâ€™, which ACEP acknowledges â€œâ€¦not intended to be construed or to serve as the definitive reference for CMS OPPS coding.â€ Lastly, the proposed policy seems unclear as to how the MCO would obtain information that may not be separately reportable on a clean claim. If the MCO intends to request records for that information prior to payment, we believe such a request would create potential conflict with state law, RS 46:460.76, which prohibits prepayment review by Medicaid MCOs except under certain circumstances. As always, if the Department has any questions or needs additional information, please let us know.

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Date	Item Number and Policy	My question/comment
10/17/2024 11:07	2024-LHCC-1486- Post-operative Visits	Page 1 - Policy states in several places that the global period includes anesthesia services - this is incorrect, anesthesia is a separately payable service. Page 1 - States in several places that the global period includes follow up care provided by a physician - this should only be the surgeon (or others of his/her same group/same specialty), not other providers. Page 1 - Reference to the Decision for Surgery modifier should include the actual modifier, i.e., 57. Page 2 - References to other modifiers should include the actual modifier, i.e., #5 is modifiers 58, 78, 79, #6 is modifier 78. Page 2 - Reference to minor and major global periods should include the 'period', i.e., minor = 0 or 10 day global, major = 90 day global. Also note that on this page, policy acknowledges that the global period minor surgeries and endoscopies (0 day global) applies only to visits and other services that occur on the SAME DAY as the surgery. Page 4 - The maternity global references a post-operative period of 45 days - confirm if this is an LDH policy or only LHCC policy. This is not supported per LDH Provider Manual, nor is it consistent with all MCOs. Page 4 - Under maternity procedures it states, procedure. Visits that occur during the antepartum period, on the same date of service, or during the post-operative period of 45 days are not recommended for separate reimbursement if the procedure includes antepartum or postpartum care. - This is incorrect, all visits for maternity are billed separately with modifier TH for Medicaid. Medicaid only pays for global OB codes for crossover claims. Page 5 - Again references that claim lines containing E&M codes billed within the post-operative period of a minor, major or maternity procedure will be denied. These services are considered included in the payment for the surgical procedure. - this is incorrect maternity is billed separately for each visit with modifier TH. Page 8 - Link to CMS Global surgery booklet does not work.

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Date	Item Number and Policy	My question/comment
10/17/2024 10:43	2024-LHCC-1480- Pre-operative Visits	Page 1 - Policy states in several places that the global period includes anesthesia services - this is incorrect, anesthesia is a separately payable service. Page 1 - States in several places that the global period includes follow up care provided by a physician - this should only be the surgeon (or others of his/her same group/same specialty), not other providers. Page 1 - States the pre-operative period addresses E&M services that occur the day before or the day of surgery, a minor procedure or endoscopy - this is incorrect the day before is only for MAJOR procedures. Page 1 - Reference to the Decision for Surgery modifier should include the actual modifier, i.e., 57. Page 2 - References to other modifiers should include the actual modifier, i.e., #5 is modifiers 58, 78, 79, #6 is modifier 78. Page 2 - Reference to minor and major global periods should include the 'period', i.e., minor = 0 or 10 day global, major = 90 day global. Also note that on this page, policy acknowledges that the global period applies only to visits and other services that occur on the SAME DAY as the surgery. Page 4 - The maternity global references a post-operative period of 45 days - confirm if this is an LDH policy or only LHCC policy. This is not supported per LDH Provider Manual, nor is it consistent with all MCOs. Page 4 - Under maternity procedures it states, procedure. Visits that occur during the antepartum period, on the same date of service, or during the post-operative period of 45 days are not recommended for separate reimbursement if the procedure includes antepartum or postpartum care. - This is incorrect, all visits for maternity are billed separately with modifier TH for Medicaid. Medicaid only pays for global OB codes for crossover claims. Page 5 - Again references that claim lines containing E&M codes billed within the pre-operative period of a minor, major or maternity procedure will be denied. These services are considered included in the payment for the surgical procedure. - this is incorrect the day before is only for MAJOR procedures. Page 6 - Modifier 24 should be listed as it is to identify charges that are unrelated to the procedure in/on/during a post operative period. Page 8 - Link to CMS Global surgery booklet does not work.
2/1/2024 13:18	2024-LHCC-2235-Concert Genetics Kidney Disorders	NOT FOR 2024-LHCC-2235*** MCO Manual has an incorrect code for Opioid Prescription policy under Part 4 of Manual. It list Sickle-cell/Hb-C disease with splenic sequestration twice with both D57.212 and D57.219 as the codes. I believe D57.219 is for crisis, unspecified.

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Date	Item Number and Policy	My question/comment
12/27/2023 18:02	2023-UHC-791 Neurophysiologic Testing	Current and future medical policy for United Healthcare Community Plan for 95938 - Somasensory Evoked Potential Testing
11/3/2023 9:29	2023-HBL-2220- Provider Digital Correspondence Initiative	On behalf of its member hospitals and health systems, the LHA appreciates the opportunity to provide comments on Proposed Policy 2023-HBL-2220 â€“ Provider Digital Correspondence Initiative. We appreciate Healthy Blueâ€™s efforts to streamline health plan/provider communication. However, in this particular instance, we encourage LDH to review the proposal closely and ensure compliance with LA Revised Statutes 46:460.76, as well as 2.18.2 Claims Processing requirements detailed in LDHâ€™s MCO contracts. We believe itâ€™s important for the Department to have understanding of what type of additional information is being requested by Healthy Blue at the point of claim processing. As always, if you have any questions or need additional information, please let us know.
3/10/2023 19:33	2023-UHC-1808- Peer Clinical Review	As a representative of Brentwood Hospital, we do not agree with the changes to the peer-to-peer clinical review process. The adverse determination should be reconsidered based on the information provided during the peer-to-peer discussion to allow for timely decision making and opportunity to have the patient sign the consent to appeal prior to his/her discharge. The peer-to-peer discussion should be granted within one business day which is considered reasonable and allows for timely notification of authorization status to the facility and the patient. The peer-to-peer discussion should be allowed while the patient is still in the hospital to avoid unnecessary appeals on patients that have criteria. The physician that made the adverse determination should be available within one business day to discuss and reconsider the original decision if he/she is the only one that can overturn the original decision.

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1/11/2023 16:16	2022-HHH-1618 Non-Emergency Ambulance Transportation UM8	To Whom It May Concern: The Louisiana Ambulance Alliance (â€œthe Allianceâ€) appreciates the opportunity to comment on the recently proposed changes to your companyâ€™s policy manual affecting ambulance transportation in Louisiana. The Alliance is the membership organization for EMS providers in Louisiana. From Acadian Ambulance, the stateâ€™s largest EMS provider, to Caddo Fire District #6, one of the stateâ€™s smallest providers, we speak with one voice. For the reasons detailed below, we urge Humana Healthy Horizons (â€œHumanaâ€) to adopt the following suggestions and revise the proposed transportation policy posted on November 28, 2022. For a point of clarity, would this policy only be implemented if there is no specific state guidance or criteria? LDH currently has policies and procedures which must be followed for non-emergency ambulance transportation claims to be reimbursed. It is contained in LDHâ€™s Medicaid Manual (pgs. 70 -71) and Medicaid State Plan (TN 21-0027). The stateâ€™s policy is as follows: â€œNon-emergency ambulance services are not prior authorized. Payment for non-emergency ambulance transportation shall be made upon receipt of the completed Certification of Ambulance Transportation form.â€ The MCO manual goes into specifics and lays out what steps are necessary for NEAT claims to be reimbursed: â€œThe enrolleeâ€™s treating physician, a registered nurse, the director of nursing at a nursing facility, a nurse practitioner, a physician assistant, or a clinical nurse specialist must certify on the Certification of Ambulance Transportation (CAT) that the transport is medically necessary and describe the medical condition which necessitates ambulance services. The certifying authority shall complete the date range on the CAT, which shall be no more than 180 days. A single CAT should be utilized by the MCO for all of the

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		enrolleeâ€™s transports within the specified date range. The MCO may not require a new CAT from the certifying authority for the same enrollee during this date range. NEAT must be scheduled by the enrollee or a medical facility through the MCO or the ambulance provider. â€¢ If transportation is scheduled through the MCO, the MCO shall verify, prior to scheduling, enrollee eligibility, that the originating or destination address belongs to a medical facility, and that a completed Certification of Ambulance Transportation form for the date of service is obtained, reviewed, and accepted by the MCO or its transportation broker prior to transport. Once the trip has been dispatched to an ambulance provider and completed, the ambulance provider shall be reimbursed upon submission of the clean claim for the transport. â€¢ If transportation is scheduled through the ambulance provider, the MCO shall require the ambulance provider to verify enrollee eligibility, that the originating or destination address belongs to a medical facility, and that a completed Certification of Ambulance Transportation form for the date of service is obtained, reviewed, and accepted by the ambulance provider prior to reimbursement. The MCO shall reimburse the ambulance provider only if a completed Certification of Ambulance Transportation form is submitted with the clean claim or is on file with the MCO or its transportation broker prior to reimbursement.â€ If the procedures laid out in the MCO Manual are followed, then the ambulance provider shall be reimbursed. Since the state has specific policies and procedures covering NEAT, it seems as though this policy is moot and unnecessary if it is only applicable in the absence of state guidance. If the policy were to take effect regardless of state guidance, then the recommendation would be that it is not implemented because it would defy the current procedures contained in the MCO Manual published by LDH.

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		In addition, our recommendation would be to delete the last paragraph under the NEAT Ground Transportation Section. If a member does not meet any of the criteria listed, then a medical professional would not certify the use of an ambulance on a Certification of Ambulance Transportation Form. If the ambulance provider or the broker cannot receive a Certification of Ambulance Transportation Form, then the claim is not reimbursable per LDHâ€™s MCO Manual. A policy implementing additional reviews prior to payment of a service if a clean claim with a completed Certification of Ambulance Transportation Form is submitted ignores the MCO Manual and the Louisiana Medicaid State Plan which do not allow prior authorizations for NEAT transports. Additionally, is a Certificate of Need the same thing as a Certification of Ambulance Transportation Form? If so, the language in the policy should be changed from Certificate of Need to Certification of Ambulance Transportation Form. Once again, the Alliance appreciates the opportunity to comment on this policy and looks forward to working with Humana to resolve these issues.

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Date	Item Number and Policy	My question/comment
12/29/2022 10:37	2022-HHH-1571 NEW: Non-Emergency Ambulance Transportation	To Whom It May Concern: The Louisiana Ambulance Alliance (â€œthe Allianceâ€) appreciates the opportunity to comment on the recently proposed changes to your companyâ€™s policy manual affecting ambulance transportation in Louisiana. The Alliance is the membership organization for EMS providers in Louisiana. From Acadian Ambulance, the stateâ€™s largest EMS provider, to Caddo Fire District #6, one of the stateâ€™s smallest providers, we speak with one voice. For the reasons detailed below, we urge Humana Healthy Horizons (â€œHumanaâ€) to adopt the following suggestions and revise the proposed transportation policy posted on November 17, 2022. For a point of clarity, does this policy only cover Non-Emergency Ambulance Transportation for out-of-state transports? When reading the document, it is unclear if it covers both in-state and out-of-state non-emergency ambulance transportation (â€œNEATâ€). On page one, the Policy Section states: â€œThe Plan does not require authorization for any emergency transportation by ground or air. The Plan does require authorization for NEAT services that out-of-state ground and all air. The Plan will review these authorizations against appropriate medical necessity criteria in accordance with the standard UM process and Louisiana Medicaid requirements. All authorization requests must be accompanied by the Certificate of Ambulance Transportation (CAT).â€ The second sentence in this policy is not in line with the current MCO Manual published by the Louisiana Department of Health (â€œLDHâ€). The MCO Manual (pg. 71) states, â€œEnrollees may seek medically necessary services in another state when it is the nearest option available. All out-of-state NEAT transportation to facilities that are not the nearest available option, must be prior approved by the MCO.â€ The recommendation would be for the second sentence to be amended to state

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		â€œThe plan does require authorization for NEAT services for out-of-state ground and air when the out-of-state NEAT transportation is to a facility which is not the nearest available option.â€ This language would be in line with the current MCO Manual published by LDH. The same change would have to be made to paragraph two in the Procedure Section. The recommended change would be for the language to state: â€œ2) All out-of-state transportation to facilities that are not the nearest available option require authorization by Humana Healthy Horizons.â€ If this policy covers in-state NEAT transports, then it does not follow the current scheduling and reimbursement procedures contained in the MCO Manual. Per the MCO manual (pg. 70-71) and the Medicaid State Plan (TN 21-0027), no authorizations are necessary on behalf of the Managed Care Organizations for NEAT. The current procedure and policy which must be followed for NEAT is as follows: â€œThe enrolleeâ€™s treating physician, a registered nurse, the director of nursing at a nursing facility, a nurse practitioner, a physician assistant, or a clinical nurse specialist must certify on the Certification of Ambulance Transportation (CAT) that the transport is medically necessary and describe the medical condition which necessitates ambulance services. The certifying authority shall complete the date range on the CAT, which shall be no more than 180 days. A single CAT should be utilized by the MCO for all of the enrolleeâ€™s transports within the specified date range. The MCO may not require a new CAT from the certifying authority for the same enrollee during this date range. NEAT must be scheduled by the enrollee or a medical facility through the MCO or the ambulance provider. â€¢ If transportation is scheduled through the MCO, the MCO shall verify, prior to scheduling, enrollee eligibility, that the originating or destination address belongs

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		to a medical facility, and that a completed Certification of Ambulance Transportation form for the date of service is obtained, reviewed, and accepted by the MCO or its transportation broker prior to transport. Once the trip has been dispatched to an ambulance provider and completed, the ambulance provider shall be reimbursed upon submission of the clean claim for the transport. â€¢ If transportation is scheduled through the ambulance provider, the MCO shall require the ambulance provider to verify enrollee eligibility, that the originating or destination address belongs to a medical facility, and that a completed Certification of Ambulance Transportation form for the date of service is obtained, reviewed, and accepted by the ambulance provider prior to reimbursement. The MCO shall reimburse the ambulance provider only if a completed Certification of Ambulance Transportation form is submitted with the clean claim or is on file with the MCO or its transportation broker prior to reimbursement.â€ If the procedures laid out in the MCO Manual are followed, then the ambulance provider shall be reimbursed. The MCO Manual does not require or allow for an additional review by the MCO or its transportation broker. Thus, our recommendation would be to remove all language in this policy which provides for a clinical or UM review by Humana. Any additional review provided by the MCO or a transportation broker would defy the current procedure contained in the MCO Manual published by LDH. In addition, our recommendation would be to delete paragraph four under the Procedures Section. If a member does not meet any of the criteria listed, then a medical professional would not certify the use of an ambulance on a Certification of Ambulance Transportation Form. If the ambulance provider or the broker cannot receive a Certification of Ambulance Transportation Form, then the claim is not reimbursable per LDHâ€™s MCO Manual. As stated earlier, a policy implementing additional reviews prior to payment of a service if a clean claim with a completed Certification of Ambulance Transportation Form is submitted ignore the MCO Manual and the Louisiana Medicaid State Plan which do not allow prior authorizations for NEAT transports. Once again, the Alliance appreciates the opportunity to comment on this policy and looks forward to working with Humana to resolve these issues.

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Date	Item Number and Policy	My question/comment
12/8/2022 9:06	2022-HHH-1606- Louisiana UM Program Description	After reviewing the Humana Healthy Horizons document, UM is seeking clarification regarding the questions denoted by (**) at the end of point 1. and 2. 1. Some services do not require authorization: Hospital Service authorization for non-emergency inpatient admissions for normal newborn deliveries (Model Contract 2.12.8.7.2) **Do they allow any labor days without authorizations or will they require an auth for any labor days ? 2. Regarding the peer to peer process: Informal Reconsideration/Peer to Peer Review This informal reconsideration process allows the requestor a reasonable opportunity to present evidence, and allegations of fact or law, in person and in writing. [42 CFR Â§438.402(c)(1)(ii) (Model Contract 2.12.6.4.3.1)The informal reconsideration will occur within one (1) business day of the receipt of the request and will be conducted between the provider rendering the service and the Planâ€™s physician who made the adverse determination, or a clinical peer designated by the Medical Director, if the physician who made the adverse determination cannot be available within one (1) business day. (Model Contract 2.12.6.4.3.3) **It states the peer to peer needs to be conducted within one business day from the receipt of the request for peer to peer. How long do we have to set up the peer to peer? Some plans are 3 days, 5, 10 or 14 ? ** How will retros be handled when the patient discharges on a weekend and the auth is started on a Monday? Will this fall into the retro category of 30 days or will this be considered normal initial/concurrent review turnaround times?

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Date	Item Number and Policy	My question/comment
11/24/2022 10:13	2022-LHCC-1416-Transportation Policy	The Louisiana Ambulance Alliance (â€œAllianceâ€) appreciates the opportunity to comment on the recently proposed changes to your companyâ€™s policy manual affecting ambulance transportation in Louisiana. The Alliance is the membership organization for EMS providers in Louisiana. From Acadian Ambulance, the stateâ€™s largest EMS provider, to Caddo Fire District #6, one of the stateâ€™s smallest providers, we speak with one voice. For the reasons detailed below, we urge Louisiana Healthcare Connections (â€œLHCCâ€) to adopt the following suggestions and revise the proposed transportation policy posted on October 11, 2022. The Alliance understands that the policy restates current Medicaid and Medicare policies; however, we would like to recommend that new language be used when defining certain terms. The defined terms section in your proposed policy currently states: Terms utilized in the published Medicaid fee schedule are defined as follows: â€¢ Basic Life Support (BLS): Emergency medical care administered to the EMT basic Scope of practices; â€¢ Advanced Life Support (ALS): Emergency medical care administered to at least the Level of an emergency medical technician-paramedicâ€™s scope of practice; and â€¢ Specialty Care Transport: Interfacility transportation of a critically injured or ill Beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of services beyond the scope of the EMT-Paramedic. In the 2022 legislative session, the Louisiana legislature passed ACT 644 which placed definitions for the ALS and BLS levels of service into statute. La. R.S. 40:1131 now states the following:

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		(25) "Advanced life support" or "ALS" means the provision of medically necessary supplies and services by EMS practitioners who are licensed at least to the level of advanced emergency technician or equivalent. (26) "Basic life support" or "BLS" means the provision of medically necessary supplies and services by EMS practitioners who are licensed at least to the level of emergency medical technician. Thus, any policies put in place by any managed care organization should follow provisions currently in statute. Our recommendation would be for LHCCâ€™s transportation policy to adopt the definitions which were recently placed in statute in lieu of those contained in the proposed policy. If you need anything from us, please do not hesitate to contact us.
11/21/2022 10:40	2022-LHCC-991-Concurrent Review	Can we please verify if an auth will be required for observation now? And If so, if an auth is required will clinicals now be required for observation?
6/20/2022 14:36	2022-ABH-1333-OOS hospital stays	The LHA would encourage LDH to engage in further review of 2022-ABH-1333. Although the proposed policy does not comply with the statutorily prescribed format, we believe this proposal is seeking to require out-of-state hospitals to submit to â€œan independent review by Optum, a contracted vendor, in the event the claim amount is in excess of $50,000.â€ The proposed policy offers no timeline for the processing of the claim, nor an avenue or timeline of dispute resolution if the MCO or their contracted vendor makes a determination with which the provider disagrees. We would encourage LDH to require Aetna to provide significantly more detail for this proposed policy prior to making any formal decision.

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Date	Item Number and Policy	My question/comment
1/13/2022 13:52	2021-ACLA-1177 Potential Upcoding of Surgical Services	On behalf of the Louisiana Rural Mental Health Alliance, I would urge the department to reject this proposed policy seeking to implement prepayment review. While our members do not provide any of the services outlined in the proposed policy, we are nonetheless deeply concerned that approval of this policy will lead to the rapid expansion of prepayment review being used in a manner that simply creates unnecessary administrative burden for providers as they seek payment for claims rather than serving as a tool to protect program integrity. We strongly believe that prepayment review should only be implemented directly by the department and in strict conformance with the provisions of the Medical Assistance Programs Integrity Law.
3/3/2021 11:10	2020-LHCC-680-Provider Reimbursement	The policy is proposing to remove 5.7a "The PLAN shall reimburse providers for emergency services rendered without a requirement for service authorization of any kind," and replace it with " The plan shall not deny payment for treatment when a representative of the PLAN instructs the member to seek emergency services." My question- Is the Provider considered to be a representative of the PLAN? If your Plan requires the patient to contact LHC prior to arriving to the ER why would the ER Provider be held financially reliable for treating the patient. By law, the Provider can not turn a patient away who seeks medical attention in the ER setting. This change will also create a ethical issue because you are not to medically treat based on payment source.

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8/3/2020 15:36	2020-HBL-250 Provider Manual	On behalf of the Louisiana Hospital Association (LHA), the trade association for more than 150 hospitals and health systems in the state, we would like to express concern over a proposed section of new policy included in the proposed revision of the Healthy Blue Provider Manual, Item Number 2020-HBL-250. Specifically, on page 97 of the PDF document, under the heading â€œOutpatient/Ambulatory Surgery,â€ the document shows new language being added as follows: â€œEmergency and Observation services rendered within one (1) day of a Same Day Surgery, and all pre-admission (workup) services shall be included in the Same Day Surgery rate.â€ This new language is concerning as it appears to be more expansive than the existing requirements set forth in the Hospital Services Provider Manual. Pertinent language from the Medicaid Hospital Provider manual which can be found in Chapter 25, Section 25.3 under the heading â€œOutpatient Surgeryâ€ provides: â€œâ€¦All other charges associated with the surgery (for example, observation, labs, radiology) must be billed on the same claim form as the Ambulatory surgery chargesâ€¦â€ In contrast, the proposed Healthy Blue policy purports to limit reimbursement for any â€œemergencyâ€ or â€œobservationâ€ services simply because they were rendered within one (1) day of the outpatient surgery and seemingly without regard as to whether those services had any association with the surgery. We would urge LDH to seek greater clarification of the proposed policy in order to determine whether it conflicts with existing Medicaid policy.

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Date	Item Number and Policy	My question/comment
11/22/2019 16:29	2019-Healthy Blue-95 MHR PSR Provider Bulletin	The Louisiana Hospital Association appreciates the opportunity to comment on proposed MCO policies/procedures as provided by Act 319 of the 2019 Session. We have reviewed the above referenced policy and do not believe this submission by Healthy Blue is compliant with the provisions of Act 319. The proposed Healthy Blue policy implies a change, but does not appear to completely meet the following requirements as specified in the Act: (1) Include both the existing policy or procedure and the proposed policy or procedure, with the proposed language in the text printed in boldface type and underscored; (2) All present policy or procedure language and punctuation which are to be deleted shall be struck through.
11/22/2019 16:27	2019-LHCC-25 UM Communicatio n Services	The Louisiana Hospital Association appreciates the opportunity to comment on proposed MCO policies/procedures as provided by Act 319 of the 2019 Session. We have reviewed the above referenced policy and do not believe this submission by LHCC is compliant with the provisions of Act 319. The proposed LHCC policy implies a change, but does not appear to completely meet the following requirements as specified in the Act: (1) Include both the existing policy or procedure and the proposed policy or procedure, with the proposed language in the text printed in boldface type and underscored; (2) All present policy or procedure language and punctuation which are to be deleted shall be struck through. While there is language represented on page 5 of 6 that is bolded and underscored and has the appearance of a proposed change, we do not believe this is the proper representation of the change as it is not represented in its proper place and context of the submitted document.
11/22/2019 16:25	2019-Healthy Blue-49 PA Req N Supervision for Hyperbaric O2	The Louisiana Hospital Association appreciates the opportunity to comment on proposed MCO policies/procedures as provided by Act 319 of the 2019 Session. We have reviewed the above referenced policy and do not believe this submission by Healthy Blue is compliant with the provisions of Act 319. The proposed Healthy Blue policy implies a change in the policy, but does not appear to meet the following format requirements as specified in the Act: (1) Include both the existing policy or procedure and the proposed policy or procedure, with the proposed language in the text printed in boldface type and underscored;

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		(2) All present policy or procedure language and punctuation which are to be deleted shall be struck through.
11/22/2019 16:24	2019-Healthy Blue-80 SBIRT Flier Update	The Louisiana Hospital Association appreciates the opportunity to comment on proposed MCO policies/procedures as provided by Act 319 of the 2019 Session. We have reviewed the above referenced policy and do not believe this submission by Healthy Blue is compliant with the provisions of Act 319. The proposed Healthy Blue policy implies a change in the policy, but does not appear to meet the following format requirements as specified in the Act: (1) Include both the existing policy or procedure and the proposed policy or procedure, with the proposed language in the text printed in boldface type and underscored; (2) All present policy or procedure language and punctuation which are to be deleted shall be struck through.
11/22/2019 16:21	2019-Healthy Blue-96 ICD-10 Coding Tips Sheet Flier	The Louisiana Hospital Association appreciates the opportunity to comment on proposed MCO policies/procedures as provided by Act 319 of the 2019 Session. We have reviewed the above referenced policy and do not believe this submission by Healthy Blue is compliant with the provisions of Act 319. The proposed Healthy Blue policy implies a change in the policy, but does not appear to meet the following format requirements as specified in the Act: (1) Include both the existing policy or procedure and the proposed policy or procedure, with the proposed language in the text printed in boldface type and underscored; (2) All present policy or procedure language and punctuation which are to be deleted shall be struck through. Additionally, we are uncertain about the intent of this "tip sheet" and its intended use. We believe that policies and procedures should be clearly denoted.

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11/22/2019 16:17	2019-Healthy Blue-94 SUD Criteria for Prior Authorization	The Louisiana Hospital Association appreciates the opportunity to comment on proposed MCO policies/procedures as provided by Act 319 of the 2019 Session. We have reviewed the above referenced policy and do not believe this submission by Healthy Blue is compliant with the provisions of Act 319. The proposed Healthy Blue policy implies a change in the policy, but does not appear to meet the following format requirements as specified in the Act: (1) Include both the existing policy or procedure and the proposed policy or procedure, with the proposed language in the text printed in boldface type and underscored; (2) All present policy or procedure language and punctuation which are to be deleted shall be struck through.
11/22/2019 16:16	2019-Healthy Blue-38 WAVE CG DME 46 Pneumatic	The Louisiana Hospital Association appreciates the opportunity to comment on proposed MCO policies/procedures as provided by Act 319 of the 2019 Session. We have reviewed the above referenced policy and do not believe this submission by Healthy Blue is compliant with the provisions of Act 319. The proposed Healthy Blue policy implies a change in the policy, but does not appear to meet the following format requirements as specified in the Act: (1) Include both the existing policy or procedure and the proposed policy or procedure, with the proposed language in the text printed in boldface type and underscored; (2) All present policy or procedure language and punctuation which are to be deleted shall be struck through.
9/3/2019 10:46	2019-HBL-1 Modifier Usage RP (4.19.19)	After reviewing Exhibit A: Reimbursement Modifiers Listing*, I noticed that modifier 62 is being changed from â€œCosurgeonsâ€ to â€œTwo Surgeonsâ€. By any chance, can modifier 62 continue to be listed as â€œCo-Surgeonâ€ to assure it cross references with 2019-HBL-2 Modifier 62 (8.1.19) reimbursement policy which will also support the use of the standard medical terminology?