Managed Care Policies Procedures Public Comments

Date Submitted	Item Number and Policy	My question/comment
9/14/2020 10:09	2020-PHARM-670 Oxbryta	After reviewing the proposed changes as it relates to Oxbryta, I have some concerns that it may create barriers to therapy for some patients. Oxbryta is a Hemoglobin S polymerization inhibitor that is indicated to help increase hemoglobin in sickle cell patients ages 12 and older. It was found to increase hemoglobin on average by 1 g/dl. This is of significant importance for individuals who suffer from chronic anemia resulting in chronic complications such as sickle cell retinopathy, avascular necrosis, leg ulcers, pulmonary hypertension, proteinuria, stroke, and iron overload from multiple blood transfusions. Many of our patients that have these chronic complications may or may not experience frequent sickle cell pain crises and as a result may or may not require Hydroxyurea. Hydroxyurea is indicated to help increase fetal hemoglobin and decrease the frequency of vaso-occlusive crises. Although both medications are indicated for individuals with a diagnosis of Sickle Cell disease, they are not both indicated to treat the same complication. It's important to remember when making policies that sickle cell disease manifests itself differently in each patient and not all sickle cell therapies are appropriate for every patient. In my clinical experience, our patients have seen great benefit with taking Oxbryta and we want to ensure that all of our patients are able to continue therapy without barriers to care.
9/13/2020 14:33	2020-PHARM-670 Oxbryta	Global Blood Therapeutics would like to thank the board for this opportunity to provide written comment on the proposed criteria for Oxbryta (voxelotor), a first in class, oral hemoglobin S polymerization inhibitor indicated for the treatment of sickle cell disease (SCD) in adults and pediatric patients 12 years of age and older. This indication is approved under accelerated approval based on increase in hemoglobin (Hb). Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s). The root cause of SCD is polymerization of Hemoglobin S, which leads to sickling of red blood cells and causes red blood cell destruction (hemolysis), anemia and occlusion of blood vessels. All SCD patients have anemia and decades of published studies demonstrate a significant association between anemia and end organ complications such as stroke, mortality, kidney disease, and pulmonary vasculopathy.1 Oxbryta is the first approved treatment that directly inhibits the polymerization of Hemoglobin S. This results in reduced red blood cell sickling which increases hemoglobin and reduces hemolysis thereby improving anemia, which is a fundamental presentation of sickle cell disease. This is different from other therapies that have focused on treating or reducing symptoms such as pain crises/vaso-occlusive crisis (VOCs). Patients with SCD have very few treatment options for this devastating disease. Oxbryta offers: •Novel mechanism of action directly inhibiting HbS Polymerization •Once daily oral tablet •Rapid onset of efficacy showing hemoglobin increases in as early as 2 weeks •No extensive monitoring or titration required •Data to date has shown it is well tolerated •Use as monotherapy or in combination with hydroxyurea Global Blood Therapeutics supports the safe and appropriate use of Oxbryta tablets. _____ Would the committee consider removing the 4th bullet under the approval criteria? (requirement of members to have had two or more pain crisis in past 12 months)

8/12/2020 14:05	2020-PHARM-67 Oxbryta	• I have been a sickle cell provider (and Louisiana State Sickle Cell Committee Member) for more than 15 years. The criteria noted in your proposed managed care policy for Oxbryta should be re-evaluated. My recommendations are noted below. Additionally, I would respectfully like to request an opportunity to appear in person to provide education regarding sickle cell disease. First, the life expectancy of patients with sickle cell disease in the United States remains < 45 years of age. This is NOT exclusively or primarily related to severe vaso-occlusive events, but is directly related to end organ damage that is a direct result of chronic hemolysis, iron overload and infarction events that are often silent. With this in mind please review my comments noted with your recommendations below: The recipient is 12 years of age or older on the date of the request; AND • The recipient has a diagnosis of sickle cell disease; AND • If possible, voxelotor (Oxbryta®) is prescribed by, or the request states that this medication is being prescribed in consultation with, a hematologist or oncologist; I agree with this completely. Patients with sickle cell disease should be seen by an experienced hematologist/sickle cell provider annually. This would facilitate both appropriate prescribing AND management. It should NOT read if possible, it should read "must." AND • The request lists dates of TWO or more sickle cell-related pain crises within the previous 12 months, where painful crisis is defined by EITHER: o a visit to an emergency room/medical facility for sickle cell disease-related pain which was treated with a parenterally administered narcotic or parenterally administered ketorolac; OR o the occurrence of chest syndrome, priapism, or splenic sequestration; AND The should NOT be listed as a requirement, but should be listed as "OR" with: Chronic Hemolytic Anemia (below normal hemoglobin, elevated LDH and elevated bilirubin) OR Serum Ferritin >1000, positive Ferri-scan, or liver biopsy - consistent with iron overload OR
8/11/2020 12:01	2020-PHARM-67 Oxbryta	I am writing to you regarding the drug, Oxbryta, which is manufactured by Global Blood Therapeutics. This drug has, as an indication, improvement in hemoglobin and in parameters associated with hemolysis. The trial of Oxbryta was not sufficiently powered to allow an analysis of its effect on vaso-occlusive crisis. However, its ability to improve the hemoglobin of individuals with sickle cell disease is impressive and individuals with sickle cell disease who have been placed on the drug have remarked that they have more energy, feel so much better. One patient informed me that the drug had been "a game changer." Many times, the problems associated with chronic anemia have been down-played. Yet, chronic anemia and hemolysis are associated with chronic fatigue, cognitive difficulties, the development of stroke, cardiomegaly, development of pulmonary hypertension and so much more. The effect of the drug is independent of the effects of hydroxyurea. It must be remembered that there are numerous reasons why an individual may not be able to be on hydroxyurea. These include hypersensitivity to the drug, inability to tolerate the medication due to neutropenia, megaloblastic anemia, nausea, concerns about its possible carcinogenic potential, potential teratogenic effect, or its leading to hypospermia. Oxbryta has the potential to allow individuals to live a more normal life. I would hope that those who have a primary professional caregiver such as an NP or general practitioner might be able to avail themselves of this medication and others that might come through the pipeline. Also, alleviation of anemia by itself should be a commendable goal. There should not be tacked onto the requirements for prescribing the drug a proviso that crisis had to have been present. We would hope that Medicaid insurers of those with sickle cell disease would be sensitive to the needs of those who are their clients and provide them with the medication(s) that can enhance their lives.

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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 "Outpatient/Ambulatory Surgery," the document shows new language being added as follows: "Emergency 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." 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 "Outpatient Surgery" provides: "…All other charges associated with the surgery (for example, observation, labs, radiology) must be billed on the same claim form as the Ambulatory surgery charges…" In contrast, the proposed Healthy Blue policy purports to limit reimbursement for any "emergency" or "observation" 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.
2/28/2020 20:51	2020-ABA-1 ABA Required Documenation per Codes	I've reviewed the documentation guidelines outlined. I appreciate having a standard outlined clearly. However I have some concerns: 1. The dating references Jan 1 2019. It's inappropriate to backdate guidelines/standards now. It should be dated forward for once guidelines are outlined and shared with all providers. 2. Data sheets should be a part of the accepted documentation. They need to be accompanied by notes but not excluded. Data sheets have the most information about what occurred and are the primary source for a session. 3. Some of the language in what should be included in the daily note is concerning. For an RLT to document each intervention used that day. Multiple are used a day and simultaneously. Thank you

2/28/2020 20:49	2020-ABA-4 Applied Behavior Analysis Fee Schedule Coding Update	The rates for the fee schedule are not adequate. Medicaid has decreased the rate over the years, making it harder to get more providers, as well as to get and retain quality providers, and whereas it didn't decrease this year, it also is still below what is necessary for providing quality services. On top of decreasing rates, medicaid continues to increase the demands. Increasing demands and stress without compensation of the increased workload leads to burnout and reduction in services. Also, BCBA's should be paid a higher rate for providing therapy to clients than someone with no ABA experience/degree at a bachelors level. Same for BCaBA's; please bring back rate options for higher level therapy services. Also, the three original codes were a lot more self-explanatory and easier, so less room for error. Please consider going back to a smaller, easier list, as well as an increased rate. Please also consider allowing group parent training with client codes. This is a HUGE way to help with generalization of skills, as well as aid in transition of services. Group rates are also too low. I love that there are now group options for services, and that you now reimburse for multiple therapists. Please consider doing the rate for per therapist with a cap, as sometimes the severely aggressive clients take three therapists and a supervisor, and older aggressive clients may take even more, especially in community based services, to ensure safety. Thank you for recognizing this need and making this available for our clients, as providing services to clients with more destructive behaviors requires more resources and isn't sustainable without the added compensation for those resources. We appreciate you giving us the opportunity to provide feedback, and your consideration in all of this.
2/28/2020 18:34	2020-ABA-1 ABA Required Documenation per Codes	My first concern is that this states that these requirements are for "dates of service on or after Jan. 1, 2019), but aren't expected to have final posted expectations until August 2020. We should not be held liable for documentation requirements before they have been finalized and posted for all providers. For code 97151 requirements: Assessments and data collection should be able to be used for documentation of providing the service. Also, the maximum time allowed for 97151 should be adjusted due to the large amount of requirements to complete the service. Other companies allow 6 hours, and it really takes longer than that to complete, especially for an initial plan. The updates in the treatment plan with descriptions, along with the analyzed data, graphs, and the formal assessments should count as documentation. A separate session note should not be required. 97153/0373T/97154: progress made/not made (other than the data collected) and future plans are not tech duties; this should not be part of a therapist session note, but of supervision documentation. Also, data collection should be accepted as documentation of providing the service, as well as meeting these requirements. Also, parent involvement belongs in parent training notes, not therapy session notes. 97155: Data collection should be accepted as documentation of services. 20% of supervision allowed is great, but is a lot to be required; ethical requirements by the national board is 5%. 97156/97157/97158: Data collection should be accepted as documentation of services. for 97158, 20% required is a lot, but great to have that as an option.

2/28/2020 16:11	2020-ABA-4 Applied Behavior Analysis Fee Schedule Coding Update	In reference to my previous posting there were 2 typographical error's. These sentences should read as follows: Any additional notes should only serve to clarify the data and should NOT be used to supplant the data Again, narrative or anecdotal information DO NOT represent a true way to illustrating progress.
2/28/2020 15:14	2020-ABA-1 ABA Required Documenation per Codes	DATA COLLECTION: In general the statement "data collection is insufficient for medical records" may infer that data should not be part of a medical record. The data are the only objective component to the record. Behavior Analysts have to rely to data to make decisions. It might be better to state the collection of raw data alone is not sufficient for a complete medical record. It is likely important for data (raw and graphical) to make up a substantial part of the record otherwise the information provided may be highly subjective and less than accurate. Saying something occurred is not the same a having evidence of what did or did not occur. Any additional notes should only serve to clarify the data and should be used to supplant the data. I believe strongly this would fly in face of generally accepted behavior analytic procedures. What is being inferred is that the narrative or anecdotal information is valued more than the actual data generated within the session. I argue that this might lead to LBAs minimizing the importance good data and that will likely lead to ABA services provide with much less fidelity. 97153 Code: It was requested that the documentation include a specific intervention. I doubt only one ABA intervention would be involved. Considering the potential source of the problem there are likely several. Is this information required by other types of providers? The response to the intervention is found in the data and not in narrative or anecdotal notes. The progress made is determine by the graph. Hence the important of the data. Again, narrative or anecdotal information represent a true way to illustrating progress. The rest of the information requested with this may not be in a scope of competence of the RLT (who provides the service with this code). For example, determining "future plans" (I'm assuming this is referring to future treatment plans) is related to an analysis conducted by the supervisor (LBA). Additionally, documentation of parent involved/family changes for this code is not necessarily applicable because in most cases the parent is not involved in the delivery of the code's service provision and family changes may not be information accessible to the RLT. The compliance with the target and the response are again found in the actual data generated within the session. Other codes: It should be noted that the above information is very similar to what is requested for the remaining codes. I have similar concerns because the information is not necessarily germane to the service provided within the code description and doesn't add anything meaningful regarding documentation that could not be obtained from raw and graphical data with appropriate clarifying information.

2/28/2020 15:00	2020-ABA-1 ABA Required Documenation per Codes	Comments are broken down based on each item that was included in the documentation guidelines per code with comments for each one. I only commented on the codes that I use most often in my practice. 97153 •Requirements in the ABA Medicaid Manual (Data collection is insufficient for a medical record.) – I think that it is great to be working on documentation guidelines for ABA providers! It would be great if we could have some discussion about the pieces that make data collection insufficient for the medical records and use that as a base for the documentation guidelines. I do agree that there are somethings that are not going to show in the data and those things should be included in the sessions note. Looking at the reasons why data alone is insufficient would serve as a good guide of what should be included in the note. •What specific ABA intervention used -The definition of code 97351 is, " behavior treatment by protocol." The protocol is developed by the supervising LBA and includes the specific procedures that are to be used. The protocol specifies the specific antecedent and consequences that should be used for each teaching trial. These are decisions that are made LBA prior to the 97153 service being provided. Evidence should be provided that the individual implementing 97351 was following the protocol that was created by the LBA. The data collected during the service is one piece of evidence that can be provided. The session note that should include some of the items that the student did well with and had trouble with which is further evidence. The session note is a brief summary. It does not include all of the interventions used, behaviors that occurred, or teaching that took place. This information is all found in the protocol that is being implemented as well as in the data. •What was the response to the intervention – ABA is a research-based field that relies on objective data when determining the effectiveness of a treatment. It would not be appropriate for an unlicensed individual to make an assumption on the response to intervention based on their experience. The supervising LBA analyzes data in order to make decisions on if the intervention was effective and makes changes to the protocol when appropriate. •Any notes risks/problem areas – It is appropriate to include challenges that were faced during the session in the session note. There are times that there may be a lower data count due to lack of motivation, new behaviors that occurred, or high rates of stereotypical behavior. These "problems" should be noted in the session not and provide justification for the lower number of data points that were collected during the service. It is not appropriate to include "problem areas" in regards to skill deficits. Skill deficits are measured using objective assessments and are not a part of this service. •Significant problem not associated with objective, - I am unsure of what this means. Is it a typo? The previous bullet point should cover any "problem areas." Maybe I misinterpreted the previous point and my response for that one should go here. Consider rewording this and the previous bullet point for clarity. •Future plans – "treatment by protocol" is the definition for this code. When implementing this service, the individual is following the protocol. The LBA, with parent input, is the only one qualified to make decisions regarding the "future plans" of the items on the protocol. It is not appropriate for someone implementing this code to make comments regarding "future plans." •Documentation of parent involvement – this code coves LBAs, SCABAs, and RLTs. It does not cover parents. Therefore, it would be odd to document parent
2/28/2020 14:46	2020-ABA-1 ABA Required Documenation per Codes	Requirements for 97153 are redundant and in many cases unnecessary. I would not feel comfortable with an RLT being responsible for completing many items required without immediate oversight. In many cases this would be a violation of confidentiality. Majority of required information is provided in treatment requests and not in line with session documentation for many other mental health professionals. As written, the supervision requirements for 97155 would far exceed the requirements outlined in the Louisiana Behavior Analyst Practice Law.
2/28/2020 9:55	2020-ABA-1 ABA Required Documenation per Codes	The proposed session note requirements for the 97153 codes, do not reflect that of the expertise level of an RBT. Identifying future plans or the effects of setting events on learning are rolls of the BCBA. Data collected, as well as programming documentation reflects many of these areas including current goal, interventions in place, and progress towards achieving the goal. Additional observational notes will be repetitive and require time taken away from direct services with the client. The proposed session note requirements for 97158 code, reflects having families/caregivers grouped together rather than clients.
2/27/2020 21:02	2020-ABA-1 ABA Required Documenation per Codes	The documentation requirement for session notes for CPT code 97153 seem excessive for a 15 minute session.

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2/27/2020 17:09	2020-ABA-1 ABA Required Documenation per Codes	Good afternoon, I feel it is my responsibility to comment upon the policy listed above (2020-ABA-1) and the grave concerns I have with the specific notion that states "data collection is insufficient for a medical record." Based on the focus on objectivity and data driven decisions within our field along with the years of research to support the use of data driven decision making and in turn the results of such efforts, not using data collections as a form of notion of one's progress is extremely concerning. I am writing to state my concerns with data not being a sufficient means to record medical services. It would be greatly appreciated if consideration was made to establish that data collections and or visual representations of such data (i.e., graphs) were written into the alignment of policy 2020-ABA-1 regarding the required documentation per codes. Thank you, Tricia Clement, Phd, LBA, BCBA-D
2/27/2020 13:05	2020-ABA-1 ABA Required Documenation per Codes	I am writing on behalf of the Louisiana Coalition for Access to Autism Services (LCAAS). LCAAS is a coalition of ABA therapy providers with a mission of expanding access to high-quality autism services throughout Louisiana. We have a concern that some of the documentation requirements contained in the proposed rules are not only overly burdensome, but also require certain professionals to provide information not within their scope. The requirements for code 97153, for example, pertain to services provided directly by a registered behavior technician (RBT or "line tech"). Line techs have a significantly lower level of training and education than licensed behavior analysts who provide the supervision. Line techs also may not have access to information such as future plans and the full scope of parent involvement in the treatment plan, which are requirements included in the proposed rules. The proposed documentation requirements will thus be burdensome to line techs on multiple fronts based on their scope and the length of time required. Additionally, much of the information requested (barrier, parent involvement response to intervention) are reported in the 6th month treatment review, which we believe is sufficient. Separately, the language "It is not required that a separate session note be created for every 15 minute unit; just ensure that all units billed are accounted for" is vague. It does not provide BCBAs or line techs with certainty over what documentation is required. LCAAS is happy to meet with LDH officials to discuss the documentation requirements in detail.
2/27/2020 11:11	2020-ABA-1 ABA Required Documenation per Codes	I have concern with the recommended documentation for the 97153 and 97154 codes specifically. As these codes (97153 in particular) are used daily, I don't believe the recommended documentation provided on a daily basis is going to yield any additional insight as to whether or not the service was completed any more than providing a data sheet, graph, objective, sign in/out or other already kept documentation would do. Further, a line technician, who may be the only person seeing the client on a specified day may provide anecdotal observations but is by no means necessarily qualified to outline the commentary that is being recommended. I also have concern with the percentage requirement for documentation of the 97155 code. 2 hours per 10 hours of therapy or 1 hour per 5 hours of therapy is not based on medical necessity. This amount of supervision does not match any recommended guidelines for ABA supervision, it does not lend to appropriate reduction of services/hours/support, or any other evidence based requirement for supervision. The content of the supervision documentation is fine, just the hours requirement is the issue.

2/26/2020 20:17	2020-ABA-2 ABA Audit Tool Overview	There are two places in the ABA Provider Audit Tool draft where requirements are not consistent with the MCO requirements/manuals as applies to documentation of professional/behavioral health services. We are requesting that LDH edit these two items to align with the MCO provider manuals and thus create consistent documentation standards, especially for those of us who are providing more than just ABA. As currently written, the LDH draft places an undue burden on providers to reprogram their electronic medical records for ABA only documentation. Location 1: Page 2, item number 4. It reads: "4. The responsible service provider's name, professional degree and relevant identification number." What we are currently required to do is provide a signature of full name followed by degree and credentials for rendering providers. Our understanding of this requirement as it should translate to the ABA Audit tool is: John Doe, MS, LBA, BCBA or Sarah Brown, BA, BCaBA, or Todd Smith, BA, or Sam Smith (no degree follows). We are not currently putting license numbers or MCO provider identification numbers (of which there are different numbers for each MCO) inside a professional signature and are requesting this never be required. We are requesting that LDH use the MCO provider manuals language here and change "relevant identification number" to "relevant credentials." Page 4, General Member Information, item 1. This currently reads: "1. Member name and MCO ID# on every page." Again, this is not reflecting the language and requirements in the current MCO provider manuals. The MCOs use the term "unique practice identifier" or "unique practice ID." For those of us using electronic medical records that also conform to traditional allied and behavioral health services, those medical records systems assign a patient a unique identifier, usually alpha and numeric, that allows unified record keeping. So if a child gets a name change due to adoption, we can run a continuous record. If the child changes MCOs, we can run a continuous record. We do not track children by MCO ID# because children may change MCOs, thus breaking the continuity of the record. Our electronic record automatically prints the unique practice identifier on each page of the record. This is also a way to identify a child without using too much protected health information. Thus, we are requesting that LDH replace the language "MCO ID# on every page" with "unique practice ID." We would like to thank LDH for the time and effort in drafting this document. It will be helpful to have going forward. We also wish to thank LDH for otherwise (these two places as an exception) being very conscious of aligning the ABA audit requirements with the standing LDH behavioral health provider audit requirements. The continuity helps with efficiency and effectiveness.

2/26/2020 19:54	2020-ABA-1 ABA Required Documenation per Codes	Code 97151 does not require an encounter note with the depth of information in the required documentation column in this draft because the plan document itself is the product of time spent in this code. The plan document stands alone and contains the prescribed elements in the encounter note description. As written, LDH would be asking providers to double document, which is inconsistent with other realms of behavioral health services provision. Instead, the required documentation should read: "Completed ABA Treatment Plan per guidelines in the LDH ABA manual. Documentation either within the treatment plan or in a session note that specifies date(s) of service and time(s) and signed per the LDH ABA manual guidelines. " 97153 LDH should specify that a session note is the equivalent of the Daily Log. The current LDH ABA manual has outlined criteria for a Daily Log that align with the drafted documentation requirements. 97155 A separate session note should not be required if the provider is documenting the provision of supervision and items otherwise listed in the LDH draft on the Daily Log, which also documents 97153. The most critical elements of documentation for 97155 are (1) start and stop times [omitted from LDH description] and (2) real time changes in prescribed treatment documented for inclusion in the treatment plan ongoingly. 97156 A separate session note should not be required for each date of occurrence if the provider is documenting the items for 1:1 family training on the Daily Log and more thoroughly capturing the training in a weekly supervision and family training note that synthesizes the full week's progress. For example, we do short bursts of family training daily (15 minutes) to best support implementation and continuity. The process and outcome are documented in a narrative weekly note that provides a bigger picture of progress. We are capturing daily start and stop times, participants, and points of emphasis of family training in the Daily Log. Because 1:1 family training is an important daily tool for us in engaging families and making sure that they are taking home and applying the critical points of the day, we ask that LDH allow providers some flexibility in this documentation. Thank you for the opportunity to comment.
2/26/2020 13:18	2020-ABA-1 ABA Required Documenation per Codes	Please see below my questions/comments regarding the required documentation per codes. 97151- does the treatment plan count as a session note if all of what was conducted/observed in the assessment is included? I feel as though a session note that is separate may be highly redundant and time-consuming when our company is already struggling to conduct the assessment and write the treatment plan in the amount of time that insurance companies are authorizing (usually 4 hours). 97152/97155- For baseline that is being conducted in order to add new targets after clients have mastered everything in their 6-month treatment plan, which code is billed for? For baseline, this may not include a full assessment being conducted. 97157- Can this include general workshops hosted by the center that apply towards the clients whose family attends (i.e., general ABA content discussed that is included in the billed client's program without specific client programming) or does client-specific discussion need to happen in order for this code to be billed? My concern is related to HIPAA but still wanting to bill accurately.
2/22/2020 10:32	2020-ABA-1 ABA Required Documenation per Codes	97151/2, 0362T. Updated treatment plan should be accepted in lieu of session note for assessments, as it necessarily requires all of the proposed documentation anyway.

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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 Communication 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; (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.

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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.
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.
10/14/2019 13:19	2019-PDL-1 Advair - PDL Changes	I thought that once all of the Bayou Health Plans merged to a single uniform PDL, it was to stay t he same and not change, for the simple fact all providers and pharmacies would be on the same page and not have to go back and forth between health plans to see which ones required PA's for which medications. That apparently was not very well thought out. If one plan is going to change the criteria for it to be approved and/or denied, it should be that way for all of them. We are right back to square one having to do PA's for nearly every single medication that is prescribed for patients, whether they have Medicare, private insurance or Medicaid, which is ridiculous. The government has micromanaged everything to the point the providers cannot even practice medicine without the interference of insurances.
9/17/2019 9:03	2019-HPA-1 Severe Combined Immunodeficiency (SCID)	The Office of Public Health, Genetics Diseases/Newborn Screening Program requests that Medicaid reference and add the LAC from Oct. 20, 2018 in the HPA regarding the addition of SCID to the Newborn Screening panel so that the MCOs know to plan for retroactive effective date back to the Rule Date drop.
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 “Cosurgeons” to “Two Surgeons”. By any chance, can modifier 62 continue to be listed as “Co-Surgeon” 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?