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Aetna Better Health® of Louisiana

Appendix A: Covered & Non Covered Services

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Section 1: Covered Services Overview, Criteria, and Limitations

Per the **Louisiana Department of Health Professional Services Provider Manual:**

> Professional services are provided by, but are not limited to, physicians, advanced practice registered nurses (RNs), certified registered nurse anesthetists (CRNAs), physician assistants, audiologists, optometrists and other health care professionals. These services are provided within the licensed individual's scope of practice, as defined by Louisiana law and are provided by, or under the personal direction and supervision of, a State Board licensed individual as authorized under Louisiana law.

This appendix outlines services covered by Aetna Better Health of Louisiana (ABHLA). ABHLA covers all services covered under the Louisiana Medicaid Program. Some services may require additional service criteria such as prior authorization or service limitations.

Section 2: Provider Requirements and Responsibilities

Approved providers can be found on our website using the online provider search tool: **https://www.aetnabetterhealth.com/louisiana/find-provider.**

All providers (both facility and ordering physicians) must be registered in the state and the health plan's registry. The provider should be a preferred provider for the health plan. Providers must also be licensed to perform the services rendered.

For a detailed view of provider requirements and responsibilities – including provider enrollment, network requirements, appointment availability standards, and more – please see the Provider Enrollment, Responsibilities, and Important Info chapter of the main **ABHLA Provider Manual**.

"Incident To" Services

"Incident to" services means services or supplies that are furnished as an integral, although incidental, part of a supervising provider's professional services. For physicians, "incident to" services include those provided by auxiliary personnel (e.g., medical assistants, licensed practical nurses, registered nurses, etc.), but exclude those provided by an advanced practice registered nurse (APRN) and physician assistant (PA). For APRNs and PAs, "incident to" services also include those provided by auxiliary personnel. For all "incident to" services, auxiliary personnel must only operate within the scope of practice of their license or certification.

Provider supervision must consist of either personal participation in the service or direct supervision coupled with review and approval of the service notes. Direct supervision is defined as the provider being present in the facility, though not necessarily present in the room where the service is being rendered, and immediately available to provide assistance and direction throughout the time the service is performed. For Office of Public Health clinics, providers must furnish general supervision, defined as under the supervising provider's overall direction and control, but the provider's presence is not required in the facility during the performance of the service.

When an APRN or PA provides all parts of the service independent of a supervising or collaborating physician's involvement, even if a physician signs off on the service or is present in the facility, the service does not meet the requirements of "incident to" services. Instead, claims for such services must be submitted using the APRN or PA as the rendering provider.

It is inappropriate for a physician to submit claims for services provided by an APRN or PA with the physician listed as the rendering provider when the physician is only supervising, reviewing, or "signing off" on the APRN's or PA's records. Services billed in this manner are subject to post-payment review, recoupment, and additional sanctions as deemed appropriate by Louisiana Medicaid.

Section 3: Reimbursement Standards

ABHLA reimburses providers for covered services based on the **Louisiana Medicaid Fee Schedule**. To qualify for reimbursement, providers must fulfill all requirements outlined by Louisiana Medicaid and ABHLA, including but not limited to provider registration and licensing requirements, medical necessity guidelines, and any service-specific requirements (such as prior authorization). For encounter, billing, and claim guidance and requirements, please see the Encounter, Billing and Claims section of the main **ABHLA Provider Manual**.

Section 4: Coverage Requirements

Medical Necessity

Medical necessity is defined as a service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the provider in accordance with Aetna Better Health of Louisiana's guidelines, policies or procedures, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the member's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.

You can view a current list of the services that require authorization on our website at **AetnaBetterHealth.com/Louisiana**. If you are not already registered for the secure web portal, download an application from the Louisiana Providers section of the site. If you have questions or would like to get training on the secure provider web portal and the Prior Authorization Requirement Search Tool, please contact our Provider Experience Department at **1-855-242-0802**.

Section 5: Covered Services

This appendix includes a list of medical services and products covered by ABHLA. Behavioral health services, durable medical equipment, pharmacy, and transportation benefits can be viewed in their respective manual sections.

For a full list of member assessment criteria and provider and facility requirements, please see chapter 2 of the **Medicaid Services Manual.**

Interpretation Services

Telephone interpretive services are provided at no cost to members or providers. Personal interpreters can also be arranged in advance. Sign language services are also available. These services can be arranged in advance by calling Aetna Better Health of Louisiana's Member Services Department at **1-855-242-0802**.

Medicaid Covered Services

Some services are covered by Medicaid but not by Aetna Better Health of Louisiana. Since these services are not covered by our Plan, you do not have to use our network providers to obtain these services.

Service	How to access
Coordinated System of Care (CSoC) (see Appendix B: Behavioral Health for description)	Contact Magellan at 1-800-424-4489.
Children's dental services	Contact either: MCNA Dental at 1-855-702-6262 TTY: 1-800-955-8771 Mon – Fri 7a – 7p, or visit **www.mcnala.net** DentaQuest at 1-800-685-0143 TTY: 1-800-466-7566 Mon – Fri 7a – 7p, or visit **www.dentaquest.net**
Nursing facility services	Contact Louisiana Options in Long Term Care at 1-877-456-1146
Personal care services for members 21 and older, with the exception of Behavioral Health Personal Care Services	Contact Louisiana Options in Long Term Care at 1-877-456-1146
ICF/DD Services	Contact the Office for Citizens with Developmental Disabilities at 1-866-783-5553
All Home & Community-Based Waiver Services	Contact the Office for Citizens with Developmental Disabilities at 1-866-783-5553
Targeted Case Management Services	Contact the Office for Citizens with Developmental Disabilities at 1-866-783-5553
Services provided through LDH's Early-Steps Program (Individuals with Disabilities Education Act (IDEA) Part C Program Services)	Contact the Office for Citizens with Developmental Disabilities at 1-866-783-5553
Individualized Education Plan (IEP) services provided by a school district	Contact the Louisiana Department of Education at 1-877-453-2721
Medical Dental with the exception of the EPSDT varnishes provided in a primary care setting	Contact either: MCNA Dental at 1-855-702-6262 TTY: 1-800-955-8771 Mon – Fri 7a – 7p, or visit **www.mcnala.net** DentaQuest at 1-800-685-0143 TTY: 1-800-466-7566 Mon – Fri 7a – 7p, or visit **www.dentaquest.net**

Cost for Services
Aetna Better Health of Louisiana has a contract with Healthy Louisiana to provide health care services with no cost sharing. This means members should not be asked to pay copay when they receive medical services.

Non-Covered Services
There are some services that Aetna Better Health of Louisiana does not cover. These include:

- Services or items used only for cosmetic purposes
- Elective abortions
- Treatment for infertility
- Experimental/Investigational procedures drugs and equipment (Phase I & II Clinical Trials are considered experimental)

Abortion Policy
Medicaid Payment for abortions is restricted and the following criteria must be met: physician must certify in own handwriting on the basis of his professional judgment the life of pregnant woman would be endangered if the fetus was carried to term. Certification statement which contains the name and address of the recipient must be specified on the claim. Terminating a pregnancy due to rape of incest must meet the following requirements: The recipient will report the act of rape or incest to police unless the treating doctor certifies in writing the victim was too physically or psychologically incapacitated to report the rape or incest and must be submitted to the Bureau of Health Services Financing along with the treating physician's claim for reimbursement for performing an abortion. Recipient will certify that the pregnancy is the result of rape or incest, and this certification will be witnessed by the treating physician. The Office of Public Health Certification of Informed Consent-Abortion will be witnessed by treating physician and sent along with hard copy of claim.

Allergy Testing and Allergen Immunotherapy
Eligibility Criteria:

Allergy testing and allergen immunotherapy is covered for members who have symptoms of allergic disease, such as respiratory symptoms, skin symptoms, or other symptoms that consistently follow a particular exposure, not including local reactions after an insect sting or bite.

Covered Services:

- In vitro specific IgE tests;
- Intracutaneous (intradermal) skin tests;
- Percutaneous skin tests;
- Ingestion challenge testing; and
- Allergen immunotherapy.

Coverage Limits:

Per member per calendar year minimums:
- 180 doses for supervision of preparation and provision of antigens other than stinging or biting insects; and
- 52 doses for supervision of preparation and provision of antigens related to stinging or biting insects;
- Allergen immunotherapy doses exceeding the above quantities when medically necessary shall be covered.

General Anesthesia/Facility Reimbursement Hospital Outpatient Dental
Additional reimbursement of $20.00 per time unit (each time unit is equal to 15 minutes). Providers must append modifier -23 to the anesthesia CPT code 00170 in addition to other appropriate anesthesia modifiers when a dental procedure is performed. The general anesthesia reimbursement formula has been revised to calculate the additional reimbursement. The additional reimbursement will be applied after all other calculations take place.

Facilities are reimbursed at least $400.00 per procedure. To receive the additional reimbursement, use CPT code 41899. To qualify for enhanced reimbursement, the procedure must take place in a hospital outpatient setting.

Anesthesia for Pain Management
ABHLA will cover epidurals that are administered for the prevention or control of acute pain, such as that which occurs during delivery or surgery, as professional services for this purpose only. Coverage for chronic intractable pain is dependent on the clinical etiology and the type of service or treatment.

If a member requests treatment for chronic intractable pain, depending on the underlying cause or anatomical defect, the provider may determine treatment or management to include physical therapy, occupational therapy, medication therapy management (MTM), epidural steroid injection (ESI) therapy, acupuncture, chiropractic, behavioral health and addiction medicine services in coordination with case management. These include some alternative treatments, and the inclusion of coverage on the Professional Services Fee Schedule will define covered treatments.

Certain Medicaid procedures or services may require prior authorization. CPT codes for the treatment of chronic intractable pain requiring PA can be identified on the Professional Services Fee Schedule.

Breast Reconstructive Surgery
Breast Reconstruction surgery performed after a mastectomy is a covered service, but breast reconstruction to establish symmetry with contralateral breast is not covered.

Cardiovascular Services
Invasive Coronary Angiography (ICA) and Percutaneous Coronary Intervention (PCI) is covered for members aged 18 and over. This policy does not apply to members who are pregnant, cardiac transplant members, solid organ transplant candidates, or survivors of sudden cardia arrest.

Eligibility Criteria for Elective ICA

ABHLA covers elective ICA and considers it medically necessary in members with one or more of the following:

- Congenital heart disease that cannot be characterized by non-invasive modalities such as cardiac ultrasound, CT, or MRI;
- Heart failure with reduced ejection fraction for the purposes of diagnosing ischemic cardiomyopathy;
- Hypertrophic cardiomyopathy prior to septal ablation or myomectomy;
- Severe valvular disease or valvular disease with plans for surgery or percutaneous valve replacement;
- Type 1 myocardial infarction within the past three months defined by detection of a rise and/or fall of cardiac troponin values with at least one value above the 99th percentile upper reference limit and with at least one of the following:
- Symptoms of acute myocardial ischemia;
- New ischemic electrocardiogram (ECG) changes;
- Development of pathological Q waves;
- Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality in a pattern consistent with an ischemic etiology; and
- Identification of a coronary thrombus;
- History of ventricular tachycardia requiring therapy for termination or sustained ventricular tachycardia not due to a transient reversible cause, within the past year;
- History of ventricular fibrillation;
- Return of angina within nine months of prior PCI;
- Members without chronic kidney disease who have Canadian Cardiovascular Society class I-IV classification of angina with intolerance of or failure to respond to at least two target dose anti-anginal medications (beta blocker, dihydropyridine or non-dihydropyridine calcium channel blocker, nitrates, and/or ranolazine); or
- High risk imaging findings, defined as one or more of the below:
- Severe resting left ventricular dysfunction (LVEF ≤35%) not readily explained by noncoronary causes;
- Resting perfusion abnormalities ≥10% of the myocardium in members without prior history or evidence of myocardial infarction;

- Stress electrocardiogram findings including ≥2 mm of ST-segment depression at low workload or
- persisting into recovery, exercise-induced ST-segment elevation, or exercise-induced ventricular tachycardia/ventricular fibrillation;
- Severe stress-induced left ventricular dysfunction (peak exercise LVEF <45% or drop in LVEF with stress ≥10%);
- Stress-induced perfusion abnormalities affecting ≥10% myocardium or stress segmental scores indicating multiple vascular territories with abnormalities;
- Stress-induced left ventricular dilation;
- Inducible wall motion abnormality (involving >2 segments or 2 coronary beds);
- Wall motion abnormality developing at low dose of dobutamine (≥10 mg/kg/min) or at a low heart rate (<120 beats/min); or
- Left main stenosis (≥50% stenosis) on coronary computed tomography angiography.

ICA for non-acute, stable coronary artery disease is not considered medically necessary, including for members with stable angina who are not interested in revascularization or who are not candidates for PCI or coronary artery bypass graft surgery.

Eligibility Criteria for Elective PCI

ABHLA covers elective PCI for angina with stable coronary artery disease and considers it medically necessary in members without chronic kidney disease who have Canadian Cardiovascular Society class I-IV classification of angina with intolerance of or failure to respond to at least two target dose anti-anginal medications (beta blocker, dihydropyridine or non-dihydropyridine calcium channel blocker, nitrates, and/or ranolazine).

Elective PCI for other cardiac conditions is considered medically necessary in members with one or more of the following:

- Heart failure with reduced ejection fraction for the purposes of treating ischemic cardiomyopathy;
- Left main stenosis ≥50% as determined on prior cardiac catheterization or coronary computed tomography angiography, if the member has documentation indicating they were declined for a coronary artery bypass graft surgery; and
- Type 1 myocardial infarction within the past three months as defined by detection of a rise and/or fall of cardiac troponin values with at least one value above the 99th percentile upper reference limit and with at least one of the following:
- Symptoms of acute myocardial ischemia;
- New ischemic electrocardiogram changes;
- Development of pathological Q waves;
- Imaging evidence of new loss of viable myocardium, or new regional wall motion abnormality in a pattern consistent with an ischemic etiology; and
- Identification of a coronary thrombus.

Elective PCI for non-acute, stable coronary artery disease is not considered medically necessary in all other member populations, including if the member is unwilling to adhere with recommended medical therapy, or if the member is unlikely to benefit from the proposed procedure (e.g., life expectancy less than six months due to a terminal illness).

Endovascular Revascularization for Peripheral Artery Disease

ABHLA covers endovascular revascularization procedures (stents, angioplasty, and atherectomy) for the lower extremity and consider them medically necessary for the following conditions:

- Acute limb ischemia;
- Chronic limb-threatening ischemia, defined as the presence of any of the following:
- Ischemic pain at rest;
- Gangrene; or
- Lower limb ulceration greater than two weeks duration.

ABHLA also covers endovascular revascularization procedures and consider them medically necessary in members with peripheral artery disease who have symptoms of intermittent claudication and meet all of the following criteria:

- Significant peripheral artery disease of the lower extremity as indicated by at least one of the following:
- Moderate to severe ischemic peripheral artery disease with ankle-brachial index (ABI) ≤0.69; or
- Stenosis in the aortoiliac artery, femoropopliteal artery, or both arteries, with a severity of stenosis ≥70% by imaging studies; and
- Claudication symptoms that impair the ability to work or perform activities of daily living; and
- No improvement of symptoms despite all of the following treatments:
- Documented participation in a medically supervised or directed exercise program for at least 12 weeks. Individuals fully unable to perform exercise therapy may qualify for revascularization only if the procedure is expected to provide long-term functional benefits despite the limitations that precluded exercise therapy; and
- At least six months of optimal pharmacologic therapy including all of the below agents, unless contraindicated or discontinued due to adverse effects:
- Antiplatelet therapy with aspirin, clopidogrel, or both
- Statin therapy
- Cilostazol
- Antihypertensives to a goal systolic blood pressure ≤140 mmHg and diastolic blood pressure ≤90 mmHg; and
- At least one documented attempt at smoking cessation, if applicable, consisting of pharmacotherapy, unless contraindicated, and behavioral counseling, or referral to a smoking cessation program that offers both pharmacotherapy and counseling.

Exclusions

ABHLA does not consider endovascular revascularization procedures for the lower extremity not medically necessary in the following circumstances:

- Claudication due to isolated infrapopliteal artery disease (anterior tibial, posterior tibial or peroneal) including members with coronary artery disease, diabetes mellitus, or both;
- To prevent the progression of claudication to chronic limb-threatening ischemia in a member who does not otherwise meet medical necessity criteria;
- Member is asymptomatic; or
- Treatment of a nonviable limb.

Peripheral Arterial Disease Rehabilitation for Symptomatic Peripheral Arterial Disease

Peripheral arterial disease rehabilitation, also known as supervised exercise therapy, involves the use of intermittent exercise training for the purpose of reducing intermittent claudication symptoms.

ABHLA covers and considers medically necessary up to 36 sessions of peripheral arterial disease rehabilitation annually. Delivery of these sessions three times per week over a 12-week period is recommended, but not required. ABHLA will direct providers to adhere to CPT guidance on the time per session, exercise activities permitted, and the qualifications of the supervising provider.

Cervical Cancer Screenings

Cervical cancer screenings are covered for members 21 and over. Members under 21 must meet one of the following medically necessary:

- were exposed to diethylstilbestrol before birth;
- have Human Immunodeficiency Virus;
- have a weakened immune system;
- have a history of cervical cancer or abnormal cervical cancer screening test; or
- meet other criteria subsequently published by ACOG.

Providers of member meeting the any of the criteria above must submit hard copy supporting documentation to the fiscal intermediary. This includes but is not limited to: initial abnormal Pap test result and subsequent abnormal Pap test results; History and Physical; Procedure note.

Cochlear Implants
Eligibility Requirements:

ABHLA covers unilateral or bilateral cochlear implants for members under 21 years of age when deemed medically necessary for treatment of severe-to-profound, bilateral sensorineural hearing loss. Implants must be used in accordance with Food and Drug Administration (FDA) guidelines.

Provider criteria and evaluation/counseling requirements can be found in the LDH **Medicaid Services Manual.**

For bilateral cochlear implants, an audiologic and medical evaluation must determine that a unilateral cochlear implant plus hearing aid in the contralateral ear will not result in binaural benefit for the member.

Covered Services:

ABHLA will cover:
- All costs for upgrades and repairs to the component parts of the implant; and
- All costs for cords and batteries
- Cochlear implant surgery as well as postoperative aural rehabilitation by an audiologist and subsequent speech, language, and hearing therapy
- Cochlear implant post-operative programming and diagnostic analysis services.

When prior authorized, ABHLA will reimburse preoperative evaluation services (i.e., evaluation of speech, language, voice, communication, auditory processing, and/or audiologic/aural rehabilitation) even when the member may not subsequently receive an implant.

The following items are non-covered expenses:
- Service contracts and/or extended warranties; and
- Insurance to protect against loss and theft.

Coding Guidance:

ABHLA will make reimbursement to the hospital at the time of surgery for both the implant and the per diem. The implant and the implantation surgery must be prior authorized by submitting the PA-01 form. After approval has been granted, the hospital must bill for the implant(s) by submitting the appropriate HCPCS code on a CMS 1500 claim form. Write the letters DME in bold, black print on the top of the form and the PA number written in item 23.

Community Health Workers
ABHLA will cover services rendered to members by qualified community health workers (CHW).

Eligibility Criteria:

ABHLA will cover CHW services if an enrollee has one or more of the following:
- Diagnosis of one or more chronic health (including behavioral health) conditions;
- Suspected or documented unmet health-related social need; or
- Pregnancy.

Covered Services:

- Health promotion and coaching. This can include assessment and screening for health-related social needs, setting goals and creating an action plan, on-site observation of member's living situations, and providing information and/or coaching in an individual or group setting.

- Care planning with the member and their healthcare team. This should occur as part of a person-centered approach to improve health by meeting a member's situational health needs and health-related social needs, including time-limited episodes of instability and ongoing secondary and tertiary prevention.
- Health system navigation and resource coordination services. This can include helping to engage, reengage, or ensure patient follow-up in primary care; routine preventive care; adherence to treatment plans; and/or self-management of chronic conditions.

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

ABHLA will not restrict the site of service which may include, but is not limited to, a health care facility, clinic setting, community setting, or the member's home. The health plan will permit delivery of the service through a synchronous audio/video telehealth modality. ABHLA will reimburse only the CPT procedure codes in the 'Education and Training for Patient Self Management' section that are provided by CHWs. The CHW are required to follow CPT guidance.

Coverage Limitations:

ABHLA will not cover the following services when provided by CHWs:

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

ABHLA will reimburse a maximum of two hours per day and ten hours per month per member.

Reimbursement:

ABHLA will reimburse CHW services "incident to" the supervising physician, APRN, or PA. A CHW who provides services to more than one member is required to document in the clinical record and bill appropriately using the approved codes associated with the number of people receiving the service simultaneously. This will be limited to eight unique members per session.

Community Health Workers in Federally Qualified Health Centers and Rural Health Clinics
Medicaid received approval from CMS to reimburse services rendered by qualified CHW in federally qualified health centers (FQHC) and rural health clinics (RHC) effective for dates of service on or after January 1, 2022. CHW service reimbursement is based on an alternative payment methodology, which allows reimbursement outside of the current Prospective Payment System rate for CHW services provided in FQHC and RHC settings. Providers will receive payment for services at the rate on file for the date of services as published on the Professional Service fee schedule on **www.lamedicaid.com.**

In order to be considered for reimbursement, FQHC and RHC claims for CHW service reimbursement may include all of the following:

- A HCPCS for the visit (T1015, H2020, or D0999);
- An evaluation and management code; and
- The corresponding CPT code for the CHW services to receive reimbursement.

If an evaluation and management code is included on the claim, reimbursement will be the rate on file for the encounter visit in addition to the rate on file for the CHW services for the date of service. If an evaluation and management code is NOT included on the claim, reimbursement will be the rate on file for the CHW services for the date of service. An evaluation and management visit must be conducted within 30 days of the CHW services.

The policy for CHW services is located in the Professional Services Provider Manual on **www.lamedicaid.com**. FQHC and RHC policy regarding billing of CHW services is located on **www.lamedicaid.com** in the respective provider manuals.

Contraceptive Implants and Intrauterine Contraceptive Systems
ABHLA covers the insertion and removal of all FDA-approved contraceptive implants and intrauterine contraceptive systems.

Corneal Collagen Cross-Linking (CXL)
Eligibility Criteria:

The CXL procedure, including the riboflavin drops and administration of UV light, is approved for patients between 14-20 years of age with progressive keratoconus.

Covered Services:

Epithelium-off photochemical CXL using riboflavin and ultraviolet A may be considered medically necessary for treatment of progressive keratoconus when conservative treatments (e.g., spectacles and contact lens) have been tried without success and the individual does not have either of the following contraindications: a corneal thickness of fewer than 400 microns or a prior herpetic ocular infection.

Coverage Limits:

Progressive keratoconus is defined as one or more of the following:

- An increase of 1 diopter (D) in the steepest keratometry value; or
- An increase of 1 D in regular astigmatism evaluated by subjective manifest refraction; or
- A myopic shift (decrease in the spherical equivalent) of 0.50 D on subjective manifest refraction; or
- A decrease > 0.1 mm in the back optical zone radius in rigid contact lens wearers where other information was not available.

Coding Guidance:

CXL can be billed using the following codes:

- 0402T: collagen cross-linking of cornea (including removal of the corneal epithelium and measurement of corneal thickness).
- J2787: riboflavin 5'-phosphate, ophthalmic solution, up to 3 mL.

Dental Care for Adults with Developmental or Intellectual Disabilities Residing in an Intermediate Care Facility
Effective 05/01/2023, in accordance with Act 366, adults 21 years of age and older with developmental or intellectual disabilities who reside in an intermediate care facility (ICF) will receive coverage for comprehensive dental care. Some diagnostic services, such as exams and some radiographic images, will be provided by the ICF. These services include D0120, D0150, D0210, D0240, D0272 and D0330. Providers should bill these services to the ICF. The following services should be billed to the beneficiary's assigned Dental Benefit Plan Manager (DBPM):

- Diagnostic services (excluding the codes listed above)
- Preventive services
- Restorative services
- Endodontics
- Periodontics
- Prosthodontics
- Oral and maxillofacial surgery
- Orthodontics
- Emergency care

Emergency Services
Aetna Better Health of Louisiana covers emergency services without requiring prior authorization for members, whether the emergency services are provided by a contracted or non-contracted provider. ABHLA will cover emergency services provided outside of the contracting area except in the following circumstances:

- When care is required because of circumstances that could reasonably have been foreseen prior to the members departure from the contracting area
- When routine delivery, at term, if member is outside the contracting area against medical advice, unless the member is outside of the contracting area due to circumstances beyond her control. Unexpected hospitalizations due to complications of pregnancy are covered.

Aetna Better Health of Louisiana will abide by the determination of the physician regarding whether a member is sufficiently stabilized for discharge or transfer to another facility.

Family Planning Services
Family planning services are available in or out of network an include:

- Seven evaluation and management office visits per year for physical examinations for both males and females as it relates to family planning or family planning-related services;
- Contraceptive counseling (including natural family planning), education, follow-ups, and referrals;
- Laboratory procedures for the purposes of family planning and management of sexual health;
- Pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the Federal Food and Drug Administration; and
- Male and female sterilization procedures and follow up tests.

Freestanding Birthing Centers
Medicaid will cover delivery services for Medicaid recipients at free standing birthing centers. Centers will be reimbursed a one-time payment for each delivery equal to 90% of average per diem rates of surrounding hospitals providing labor and delivery services. Birthing centers are allowed to bill and be reimbursed for the code vaginal delivery only with a modifier 53. Reimbursement will be 75% of the professional services published fee schedule rate for services within the licensed midwife's scope of practice. Professional providers may bill and be reimbursed for each delivery by submitting the code for vaginal delivery only on their professional claims.

Genetic Testing and Counseling
In alignment with LDH policy, ABHLA requires that genetic counseling be provided to members both before and after all genetic testing. Genetic counseling must be documented in the member's medical record and, at a minimum, must include the following elements:

- Obtaining a structured family genetic history;
- Genetic risk assessment; and
- Counseling of the beneficiary and family about diagnosis, prognosis, and treatment.

When performed by licensed genetic counselors, services are reimbursed using the procedure code specific to genetic counseling. Reimbursement for this service is "incident to" the services of a supervising physician and is limited to no more than 90 minutes on a single day of service. When performed by providers other than licensed genetic counselors, an applicable evaluation and management (E&M) code must be used.

BRCA1 and BRCA2 Testing
In alignment with the Louisiana Medicaid Professional Services Manual, genetic testing for BRCA1 and BRCA2 mutations in cancer-affected and cancer-unaffected individuals is considered medically necessary when the beneficiary:

- Has any blood relative with a known BRCA1/BRCA2 mutation

- Meets the criterial below but with previous, limited testing (e.g., single gene and/or absent deletion duplication analysis) interested in pursuing multi-gene testing
- Has a personal history of cancer, defined as one of more of the following:
- Breast cancer and one or more of the following:
- Diagnosed at age 45 or younger, or
- Diagnosed at age 45—50 with:
- Unknown or limited family history; or
- A second breast cancer diagnosed at any age; or
- At least one close blood relative with breast, ovarian, pancreatic, or high-grade (Gleason score of at least 7) or intraductal prostate cancer at any age
- Diagnosed with triple negative breast cancer at age 60 or younger;
- Diagnosed at any age with:
- Ashkenazi Jewish ancestry; or
- At least one close blood relative with breast cancer at under 50 years of age or ovarian, pancreatic, or metastatic or intraductal prostate cancer at any age; or
- At least three total diagnoses of breast cancer in patient and/or close blood relatives
- Diagnosed at any age with male breast cancer; or
- Epithelial ovarian cancer (including fallopian tube cancer or peritoneal cancer) at any age;
- Exocrine pancreatic cancer at any age;
- Metastatic or intraductal prostate cancer at any age;
- High-grade (Gleason score at least 7) prostate cancer at any age with:
- Ashkenazi Jewish ancestry; or
- At least one close blood relative with breast cancer diagnosed at age 50 or younger, or ovarian, pancreatic, or metastatic or intraductal prostate cancer at any age; or
- At least two close blood relatives with breast or prostate cancer (any grade) at any age
- A mutation identified on tumor genomic testing that has clinical implications if also identified in the germline
- To aid in systemic therapy decision-making, such as for HER2-negative metastatic breast cancer
- Has a family history of cancer, including unaffected individuals defined one or more of the following:
- An affected or unaffected individual with a 1st- or 2nd-degree blood relative meeting any of the criterion listed above (except individuals who meet criteria only for systemic therapy decision-making); or
- An affected or unaffected individual who otherwise does not met criteria above but also has a probability >5% of a BRCA1/2 pathogenic variant based on prior probability models (e.g., Tyer-Cuzick, BRCAPro, Pennll)

Genetic testing in individuals not meeting the above criteria is considered not medically necessary and are not covered.

The following CPT Codes for BRCA1 and BRCA2 genetic testing are covered where medically necessary: 81162 – 81167, 81212, 81215 - 81217

Claims for the above genetic testing services for Members under 19 years of age are not covered and may be denied.

Home Health Services
Policy 7200.72

Home health services are available to all members who meet medical necessity requirements. A POC and PA are required. For details, see the above linked policy.

Covered services include:
- Skilled nursing services
- Home health aide
- Physical, occupational or speech therapy
- Home infusion
- Wound therapy

Effective January 1, 2024, providers must clock the nursing or therapy hours in the LaSRS EVV system as directed by LDH. A service code reflecting the hours per day and days per week will be loaded with the authorization system into the EVV system for providers to clock. ABHLA must withhold or deny reimbursement for services if a provider fails to utilize the EVV system.

Extended home health (EHH) services, extended skilled nursing services, and intermittent nursing (IN) services are covered for member from birth through age 20. For members age 21+, only one visit per professional per day is covered. Daily nursing visits less than 3 hours per day for members under 21 not meeting medical necessity criteria for EHH do not require prior authorization as Intermittent Nursing Services.

Hospice

To be eligible for hospice care, a member must meet all Louisiana Medicaid eligibility criteria and be certified as "terminally ill", defined as a medical prognosis of limited expected survival, of approximately six months or less at the time of the referral to hospice, of a member who is experiencing an illness for which therapeutic strategies directed toward cure and control of the disease alone are no longer appropriate.

Members under 21 who are approved for hospice may continue to receive life-prolonging treatments focused on treating, modifying, or curing a medical condition so that the beneficiary may live as long as possible, even if that condition is also the hospice qualifying diagnosis. The hospice agency is responsible for either providing or paying for all hospice services. The hospice provider is not responsible for reimbursement for life-prolonging therapies. Reimbursement for concurrent care shall be to the providers furnishing the care and made separately from the hospice per diem.

The following core services must be available twenty-four (24) hours per day: physician services, nursing services, medical social service, counseling services, dietary counseling, bereavement counseling, pastoral care, short-term inpatient care, inpatient respite care, hospice aide and homemaker services, and therapy services.

For the duration of election, members 21 years or older waive all rights to the following covered services:

- Hospice care provided by a hospice agency other than the hospice agency designated by the beneficiary or a person authorized by law to consent to medical treatment for the beneficiary; and
- If the beneficiary is 21 years or older, any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected services for a related condition, or services that are equivalent to hospice care, except for services provided by:
- The designated hospice provider;
- Another hospice provider under arrangements made by the designated hospice provider; and
- The beneficiary's attending physician if that physician is not an employee of the designated hospice provider or receiving compensation from the hospice provider for those services.
- Beneficiaries who elect hospice services may also receive early and periodic screening, diagnosis and treatment (EPSDT), pediatric day health care (PDHC), personal care services (PCS), and intermittent or extended home health services concurrently.

Please visit the **UM Criteria** page of the ABHLA provider website for additional patient and reimbursement criteria

Human Donor Milk

ABHLA will cover human donor milk as an outpatient service for use by medically vulnerable infants.

Eligibility Criteria:

Donor human milk is considered medically necessary when the following criteria are met:

- The beneficiary is less than 12 months of age with one or more of the following conditions:
- Post-surgical nutrition;

- Organ transplantation;
- Renal disease;
- Short gut syndrome;
- Malabsorption syndrome;
- Feeding or formula intolerance;
- Failure to thrive;
- Inborn errors of metabolism;
- Immunologic disorders;
- Congenital heart disease or other congenital anomalies; or
- Neonatal abstinence syndrome.
- The beneficiary's caregiver is medically or physically unable to produce breast milk at all or in sufficient quantities, is unable to participate in breastfeeding despite optimal lactation support, or has a contraindication to breastfeeding; or the beneficiary is medically or physically unable to receive caregiver breast milk or participate in breastfeeding; and
- The beneficiary's caregiver has received education on donor human milk, including the risks and benefits; and
- A bank accredited by, and in good standing with, the Human Milk Banking Association of North America supplied the donor human milk.

NOTE: Out-of-state DME providers enrolled only to supply donor human milk will not be limited to billing only crossover claims.

Reimbursement:

Prescriptions for donor human milk must include the following:

- Number of prescribed calories per ounce;
- Total ounces prescribed per day;
- Total number of weeks donor human milk is required;
- Total allowable refills; and
- Reason for prescribing donor human milk, including beneficiary’s diagnoses.

Prior authorization is not required for donor human milk. Donor human milk is, however, subject to post payment medical review. The DME provider must submit a prescription containing all required documentation along with a hard copy claim to the department’s fiscal intermediary. Failure to provide required documentation, or if the documentation submitted fails to establish medical necessity, will result in recoupment of the payment for the donor human milk.

Imaging

X-rays

Most diagnostic testing and radiological services ordered by the attending or consulting physician are covered. When medically necessary, portable x-rays are covered for recipients who are unable to travel to a physician’s office or outpatient hospital’s radiology facility. Coverage is limited to skeletal films of a recipient’s arms, legs, pelvis, vertebral column or skull, chest films which do not involve the use of contrast media, and abdominal films which do not involve the use of contrast media.

Positron Emission Tomography (PET) Scans

PET scans (G0219, G0235, G0252, 78608, 78609, 78811-78816) and radiopharmaceutical agents (A9515, A9526, A9552, A9580, A9587, A9588) must be reported with an appropriate diagnosis indicating their medical necessity.

The payable revenue codes for PET scans are 343 and 404. These revenue codes must be billed with the appropriate accompanying CPT codes. Claims for PET scans and radiopharmaceutical agents billed without an appropriate diagnosis will be denied.

CT Scans

PA is required.

MRI
PA is required.

Maternal Fetal Medicine

Prenatal Visits
ABHLA will cover two initial prenatal visits per pregnancy (270 days). These two visits may not be performed by the same attending provider.

A member will be considered a 'new patient' for each pregnancy whether or not the member is a new or established patient to the provider/practice. The appropriate level E&M CPT procedure code must be billed for the initial prenatal visit with the TH modifier. A pregnancy-related diagnosis code must also be used on the claim form as either the primary or secondary diagnosis.

Reimbursement for the initial prenatal visit, which must be modified with TH, will include, but is not limited to, the following:

- Estimation of gestational age by ultrasound or firm last menstrual period. (If the ultrasound is performed during the initial visit, it may be billed separately. Also, see the ultrasound policy);
- Identification of patient at risk for complications including those with prior preterm birth;
- Health and nutrition counseling; and
- Routine dipstick urinalysis.

If the pregnancy is not verified, or if the pregnancy test is negative, the service may only be submitted with the appropriate level E&M without the TH modifier. ABHLA will require notification by the provider of obstetrical care at the time of the first visit of the pregnancy.

Fetal Non-Stress Test
Fetal non-stress tests is covered when medically necessary as determined by meeting one of the following criteria:

- The pregnancy is post-date/post-maturity (after 41 weeks gestation);
- The treating provider suspects potential fetal problems in an otherwise normal pregnancy; or
- The pregnancy is high risk, including but not limited to diabetes mellitus, pre-eclampsia, eclampsia, multiple gestations, and previous intrauterine fetal death.

Fetal Biophysical Profile

Fetal biophysical profiles is covered when medically necessary, as determined by meeting at least two of the following criteria:

- Gestation period is at least 28 weeks
- Pregnancy must be high-risk, and if so, the diagnosis should reflect high risk
- Uteroplacental insufficiency must be suspected in a normal pregnancy

Pediatric Day Healthcare Services (PDHC)
Eligibility Criteria

PDHC is covered for members from birth up to twenty-one (21) years of age who have a complex medical condition which requires skilled nursing care and therapeutic interventions, on an ongoing basis to preserve and maintain health status, prevent death, treat/cure disease, ameliorate disabilities or other adverse health conditions and/or prolong life. PDHC does not provide respite care, and it is not intended to be a back-up for respite care.

In order to qualify for PDHC services, a recipient must meet all of the following criteria. The recipient must:

- Be Louisiana Medicaid eligible
- Be from birth up to twenty-one (21) years of age

- Have a medically complex condition which involves one or more physiological or organ systems and requires skilled nursing care and therapeutic interventions performed by a knowledgeable or experienced licensed professional registered nurse (RN) or licensed practical nurse (LPN) on an ongoing basis to preserve and maintain health status, prevent death, treat/cure disease, ameliorate disabilities or other adverse health conditions, and/or prolong life.
- Be a candidate for outpatient medical services in a home or community-based setting; and
- Have a signed physician's order and POC for PDHC by the recipient's physician specifying the frequency and duration of services. The POC must clearly outline the skilled nursing care and therapeutic interventions that will be performed in the PDHC.
- The POC must be individualized, specific and consistent with the symptoms or confirmed diagnosis of the disease, condition, or injury under treatment, and not in excess of the recipient's needs.

All PDHC services must be prior authorized. The following documentation must be sent for each request:

- Standardized prior authorization form which must include why the services provided at the PDHC cannot be provided elsewhere, including the school system;
- Physician's most recent note documenting medical necessity for the PDHC;
- The physician's order and POC for PDHC;
- The Prior Authorization checklist indicating the recipient's skilled nursing care requirements;
- A signed parental/guardian consent form

Covered Services:

The PDHC facility Medicaid per diem rate includes the following services/equipment:

- Nursing Care
- Respiratory Care
- Physical Therapy
- Speech-Language Therapy
- Occupational Therapy
- Social Services
- Personal care services (activities of daily living) and
- Transportation to and from the PDHC facility. Transportation will be paid in a separate per diem.

The PDHC facility will provide or arrange for the transportation of the member to and from the facility because of the complex special needs of the child. The family may choose to provide their own transportation. Transportation to and from the PDHC facility is reimbursed at a daily per diem rate in accordance with 42 CFR 440.170(a).

Coverage Limits:

Services may be provided seven days a week and up to twelve (12) hours per day for qualified Medicaid recipients as documented in the plan of care (POC). For POC components, see the LDH Medicaid Services Manual.

In the event, the medical director of the PDHC facility is also the recipient's prescribing physician, ABHLA will review the order and POC for the recommendation of the recipient's participation in the PDHC Program.

ABHLA will not reimburse a PDHC for DME and supplies that are provided to the recipient through the Medicaid DME program.

The parent or guardian is to supply medications each day as prescribed by the recipient's attending physician or by a specialty physician after consultation and coordination with the PDHC facility. PDHC staff will administer medications, as ordered or prescribed, while the recipient is on site.

Coding Guidance:

The procedure codes indicate if the member is authorized for a half day or full day and includes transportation code.

- T1025 – Full day of PDHC Services over six (6) hours up to twelve (12) hours per day
- T1026 – Hourly PDHC services six (6) hours or less per day
- T2002 – Transportation services per diem

This is to be used on days when the child cannot attend for the full day so that providers can bill for the actual service hours of six (6) hours or less. These two procedure codes cannot be billed for the same day. For reimbursement purposes, PDHC services begin when the PDHC staff assumes responsibility for the care of the child and ends when care is relinquished to the parent or guardian.

Pharmacy Services
You can find a more comprehensive description of covered services in **Appendix C: Pharmacy Services**.

Post-Stabilization Services
Aetna Better Health of Louisiana covers post-stabilization services provided by a contracted or non-contracted provider in any of the following situations:

- When Aetna Better Health of Louisiana authorized the services
- Such services were administered to maintain the member has stabilized condition within one (1) hour after a request to Aetna Better Health of Louisiana for authorization of further post-stabilization services.
- When Aetna Better Health of Louisiana does not respond to a request to authorize further post-stabilization services within one (1) hour, could not be contacted, or cannot reach an agreement with the treating provider concerning the member's care and a contracted provider is unavailable for a consultation. In this situation, the treating provider may continue the member's care until a contracted provider either concurs with the treating provider's plan of care or assumes responsibility for the member's care.

Rapid Whole Genome Sequencing of Critically Ill Infants
Eligibility Criteria:

Rapid whole genome sequencing is considered medically necessary for infants less than 12 months of age who are receiving inpatient hospital services in an intensive care or pediatric unit if they meet the following criteria:

- Are suspected of having a rare genetic condition that is not diagnosable by standard methods;
- Have symptoms that suggest a broad differential diagnosis that requires an evaluation by multiple genetic tests if advanced molecular techniques, including, but not limited to, traditional whole genome sequencing, rapid whole genome sequencing, and other genetic and genomic screening, are not performed;
- Timely identification of a molecular diagnosis is necessary to guide clinical decision making, and the advanced molecular techniques including, but not limited to, traditional whole genome sequencing, rapid whole genome sequencing, and other genetic and genomic screening results may guide the treatment or management of the infant's condition;
- Have an illness with at least one of the following features:
- Multiple congenital anomalies;
- Specific malformations highly suggestive of a genetic etiology;
- Abnormal laboratory tests suggesting the presence of a genetic disease or complex metabolic phenotype like, but not limited to, an abnormal newborn screen, hyperammonemia, or lactic acidosis not due to poor perfusion;
- Refractory or severe hypoglycemia;
- Abnormal response to therapy related to an underlying medical condition affecting vital organs or bodily systems;
- Severe hypotonia;
- Refractory seizures;
- A high-risk stratification on evaluation for a brief resolved unexplained event with any of the following:
- A recurrent event without respiratory infection,
- A recurrent witnessed seizure-like event, or

- A recurrent cardiopulmonary resuscitation;
- Abnormal chemistry levels including, but not limited to, electrolytes, bicarbonate, lactic acid, venous blood gas, and glucose suggestive of inborn error of metabolism;
- Abnormal cardiac diagnostic testing results suggestive of possible channelopathies, arrhythmias, cardiomyopathies, myocarditis, or structural heart disease; or
- Family genetic history related to the infant's condition.

Covered Services:

ABHLA will cover rapid whole genome sequencing performed in the inpatient setting for infants with complex illness of unknown etiology. Rapid whole genome sequencing includes: individual sequencing, trio sequencing of the parents of the infant, and ultra-rapid sequencing.

ABHLA will reimburse rapid whole genome testing separately from the hospital reimbursement for inpatient services. The minimum reimbursement for rapid whole genome sequencing (including reimbursement for individual sequencing, trio sequencing of the parents of the infant, and ultra-rapid sequencing) is equal to the fees on the Louisiana Medicaid Laboratory and Radiology (Non-Hospital) Fee Schedule in addition to the minimum per diem as published in the Louisiana Medicaid Inpatient Hospital Per Diem Fee Schedule. Hospitals must bill the rapid whole genome sequencing claim using the appropriate CPT code on a CMS 1500 claim form. If the hospital bills electronically, the 837P must be used.

Coverage Limits:

Rapid whole genome sequencing requires prior authorization and must be ordered by the infant's treating physician. The ordering physician must be a medical geneticist or other physician sub-specialist including, but not limited to, a neonatologist or pediatric intensivist with expertise in the conditions and/or genetic disorder for which testing is being considered. Counseling is required before and after all genetic testing, and must be documented in the medical record, as per the Genetic Counseling and Testing section of the Louisiana Medicaid Provider Manual.

Respiratory Viral Panels

CPT code 87631 is deemed medically necessary in the following instances and may be performed by a PCP if needed:

- Infants receiving monthly RSV prophylaxis with palivizumab because of high-risk conditions such as prematurity, respiratory disease or cardiac disease.
- Long-term care facility residents returning to a facility, or a person of any age returning to a congregate setting.

CPT codes 87632 and 87633 are deemed potentially medically necessary only for 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.

Testing is approved for: places of service (POS) 19 – off-campus outpatient hospital, 21 – inpatient hospital, 22 – on-campus outpatient hospital, 23 – emergency room.

Testing for these services should only occur in accordance with one or more of the following instances:

- For immune-competent beneficiaries, the test must be ordered by an infectious disease specialist or pulmonologist who is diagnosing and treating the beneficiary.
- For immune-compromised beneficiaries, the test must be ordered by a clinician specialist in one of the following: infectious diseases, oncology, transplant (for any panel), or pulmonologist who is diagnosing and treating the beneficiary.

PLEASE NOTE: an exception may be made within geographic locations where the specialist(s) cannot be reasonably reached by the beneficiary; AND the beneficiary is under the care of an infectious diseases, oncology, transplant (for any panel), or pulmonologist; AND the ordering provider is located closer to the beneficiary's place of residence than

the nearest specialist. This exception is intended for beneficiaries living in rural locations with limited clinical specialist access only.

Screening Mammography
ABHLA will cover one screening mammogram (film or digital) per calendar year for beneficiaries meeting one or more of the following criteria:

- Any woman age 30 or older with hereditary susceptibility from pathogenic mutation carrier status or prior chest wall radiation.
- Provider recommendation for any woman 35 years of age or older with a predicted lifetime risk greater than 20 percent.
- Any woman who is 35 through 39 years of age. Please note: Only one baseline mammogram is allowable between this age range for beneficiaries not meeting other criteria.
- Any woman who is 40 years of age or older.

Sinus Procedures
Balloon ostial dilation and functional endoscopic sinus surgery are considered medically necessary for the treatment of chronic rhinosinusitis when all of the following criteria are met:
Uncomplicated chronic rhinosinusitis limited to the paranasal sinuses without the involvement of adjacent neurological, soft tissue, or bony structures that has persisted for at least 12 weeks with at least two of the following sinonasal symptoms:

- Facial pain/pressure;
- Hyposmia/anosmia;
- Nasal obstruction;
- Mucopurulent nasal discharge; and

Sinonasal symptoms that are persistent after maximal medical therapy has been attempted, as defined by all of the following, either sequentially or overlapping:

- Saline nasal irrigation for at least six weeks;
- Nasal corticosteroids for at least six weeks;
- Approved biologics, if applicable, for at least six weeks;
- A complete course of antibiotic therapy when an acute bacterial infection is suspected;
- Treatment of concomitant allergic rhinitis, if present; and

Objective evidence of sinonasal inflammation as determined by one of the following:

- Nasal endoscopy; or
- Computed tomography.

Balloon ostial dilation and functional endoscopic sinus surgery are not covered and not considered medically necessary in the following situations:

- Presence of sinonasal symptoms but no objective evidence of sinonasal disease by nasal endoscopy or computed tomography;
- For the treatment of obstructive sleep apnea and/or snoring when the above criteria are not met;
- For the treatment of headaches when the above criteria are not met; and
- For balloon ostial dilation only, when sinonasal polyps are present.

Skin Substitutes
Skin substitutes are covered for the treatment of partial- and full-thickness diabetic lower extremity ulcers when the member meets all of the following requirements:

A lower extremity ulcer is present and:

- Is at least 1.0 square centimeter (cm) in size;
- Has persisted for at least 4 weeks;

- Has not demonstrated measurable signs of healing, defined as a decrease in surface area and depth or a decreased amount of exudate and necrotic tissue, with comprehensive therapy including all of the following:
- Application of dressings to maintain a moist wound environment;
- Debridement of necrotic tissue, if present; and
- Offloading of weight.
- A diagnosis of type 1 or type 2 diabetes mellitus;
- A glycated hemoglobin (HbA1c) level of ≤ 9% within the last 90 days or a documented plan to improve HbA1c to 9% or below as soon as possible;
- Evidence of adequate circulation to the affected extremity, as indicated by one or more of the following:
- Ankle-brachial index (ABI) of at least 0.7;
- Toe-brachial index (TBI) of at least 0.5;
- Dorsum transcutaneous oxygen test (TcPO2) >= 30 mm Hg; and
- Triphasic or biphasic Doppler arterial waveforms at the ankle of the affected leg.
- No evidence of untreated wound infection or underlying bone infection; and
- Ulcer does not extend to tendon, muscle, joint capsule, or bone or exhibit exposed sinus tracts unless the product indication for use allows application to such ulcers.

The beneficiary must not have any of the following:

- Active Charcot deformity or major structural abnormalities of the foot, when the ulcer is on the foot;
- Active and untreated autoimmune connective tissue disease;
- Known or suspected malignancy of the ulcer;
- Beneficiary is receiving radiation therapy or chemotherapy; and
- Re-treatment of the same ulcer within one year.

Coverage Limitations
Coverage is limited to a maximum of 10 treatments within a 12-week period. If there is no measurable decrease in surface area or depth after five applications, then further applications are not covered, even when prior authorized. For all ulcers, a comprehensive treatment plan must be documented; see the LDH Medicaid Service Manual for details.

While providers may change products used for the diabetic lower extremity ulcers, simultaneous use of more than one product for the diabetic lower extremity ulcers is not covered. Hyperbaric oxygen therapy is not covered when used at the same time as skin substitute treatment.

Prior Authorization
Skin substitutes require prior authorization, and submitted medical documentation must demonstrate that the beneficiary meets all of the aforementioned requirements.

Urine Drug Screening
Presumptive drug testing is limited to twenty-four (24) total tests per member per calendar year, with no more than two (2) in one (1) month. Definitive drug testing is limited to twelve (12) total tests per member per calendar year, with no more than one (1) per month. Testing more than fourteen (14) definitive drug classes per day is not reimbursable.

NOTE: No more than one presumptive drug test AND one definitive test are reimbursed per day per member, from the same or different provider.

Definitive tests should not routinely be the first tests of choice. Rather, presumptive testing should be a routine part of initial and on-going assessment. Definitive testing is medically indicated when:

- The presumptive test was negative for prescribed medications AND the enrollee disputes the results
- The presumptive test was positive for a prescription drug with substance use disorder (SUD) potential that was not prescribed AND the member disputes the results
- The presumptive test was positive for an illegal drug AND the enrollee disputes the results.

Routine use of definitive testing following expected negative presumptive testing is not medically necessary. Definitive tests may be ordered when definitive testing for substances with potential of SUD are required based on the member-specific history and treatment plan and the indications above. American Society of Addiction Medicine (ASAM) has defined a total of 9 classes of substances with potential of SUD:

- Amphetamines
- Opiates
- Phencyclidine
- Barbiturates
- Propoxyphene
- Benzodiazepines
- Marijuana
- Cocaine
- Methadone

When choosing between G0480 and G0481, consider which drug classes are pertinent to the care of each enrollee based on the medical indications listed above; the target drug classes should be documented on the order for the test and in the medical record.

In Lieu of Services

In lieu services are additional benefits offered by the health plan that are outside the scope of core benefits and services to individual members on a case-by-case basis, based on medical necessity, cost-effectiveness, the wishes of the member and or member's family, the potential for improved health status of the member, functional necessity and what is deemed appropriate by the medical director. Those services must represent medically appropriate treatments and not be indicated as "investigational" as determined by the medical director. In that instance, the medically appropriate non-covered service may be reviewed to determine if it is also cost-effective, and if deemed so, may be approved despite the non-covered status.

Physical Health In Lieu of services

In Lieu of Services	Alternative Medicaid State Plan Service (s)
Chiropractic Services for adult age 21 and older with disorders of the spine provide medically appropriate treatment of neuromuscular disorders. No authorization is required for up to 18 treatment sessions per year. Additional sessions may require authorization.	Inpatient and Outpatient Hospitals, Physician services, nurse practitioner services, other licensed practitioner's services, laboratory and x-ray services, and prescribed drugs.

Section 6: Value Added Benefits (VAB)

ABHLA believes in whole-health approach to care. As part of our mission to provide top quality care, we cover a number of additional benefits not covered by Louisiana Medicaid to ensure our members are able to maximize their health plan coverage.

All VAB health reward incentives are loaded onto a physical reloadable card for members to use at select online or local stores.

Adult Dental Benefits

We will offer an exam and cleaning twice a year as well as a bitewing X-rays annually to adult members, every year we will cover up to $600 care including fillings and extractions. Only available to adult members aged 21 and over who do not have dental coverage through another source. Covered services include the following:

- Preventative and diagnostic services once every six (6) months
- Restorative and Oral & Maxillofacial Surgery based on tooth and surface
- Members can receive restorative services multiple times per year, but fillings for the same tooth and service are covered one every 36 months (tooth dependent)
- Extractions can be performed multiple times per year over the course of multiple visits

Aetna Better Health of Louisiana uses DentaQuest dental services. Members can call DentaQuest at **1-844-234-9834 (TTY: 711)**, Monday – Friday from 7 AM to 7 PM CT.

Members do not need a referral to see a network dental provider. Members can find a dental provider in the provider directory online at **AetnaBetterHealth.com/Louisiana**.

Beginning on July 1, 2022, adults 21 years of age and older with developmental or intellectual disabilities who are enrolled in the New Opportunities Waiver, Residential Options Waiver or the Supports Waiver will receive access to the following services:

- Diagnostic services
- Preventive services
- Restorative services
- Endodontics
- Periodontics
- Prosthodontics
- Oral and maxillofacial surgery
- Orthodontics
- Emergency care

Alternatives to Opioids

Members aged 21+ with a chronic pain diagnosis have access to $250/year for alternative pain management options.

Annual Wellness Incentives for Adults

Adults can earn gift cards after the member completes an adult checkup

- $25 gift card for completing an adult wellness visit, for members aged 22+
- $25 gift card for receiving the annual flu shot
- $25 gift card after women's annual breast cancer screening, for members aged 40-74
- $25 gift card after annual diabetic blood testing with an HbA1c result under 8% for members with diabetes
- $25 gift card after annual cervical cancer screening, for members aged 21-64
- $25 gift card for annual colorectal cancer screening, for members aged 45+

Annual Wellness Incentives for Adolescents

Children and adolescents can earn a $15 gift card after 8 well child visits within the first 30 months of life (up to $120) and a $25 gift card for completion of an annual child or adolescent well-child visit for members aged 3-21.

Asthma Home Care
Members with an asthma diagnosis who are also in case management can receive an Asthma Wellness Kit that includes items to help manage the member's condition and up to $100 for pest control, carpet cleaning, or hypoallergenic bedding.

Behavioral Health Follow-Up Visit
Members aged 6+ with a principal diagnosis of mental illness or intentional self-harm may receive a $25 reward for a follow-up appointment with a provider within 30 days of discharge after being discharged from a facility (ED or hospital) for a mental health diagnosis.

Blood Pressure Monitoring
Members can receive $10 every 3 months up to $40/year) for high blood pressure medication fills. Members with hypertension can also receive a free digital blood pressure monitor.

Career & Life Skills Training
Members 16 and older have access to a job skills training platform and General Equivalency Diploma (GED) prep and certifications as well as a voucher to cover the cost of the test.

Diabetes Care Incentive
Members aged 18-75 with a diabetes diagnosis may receive $25 for completing a diabetic retinal eye exam.

Enhanced Transportation
Members aged 18+ receive transportation services for activities such as job interviews, job training, trips to the grocery store or food bank, faith-based events, and accessing community support services not otherwise covered. Limit 10 round trips up to 25 miles per trip or 20 one-way trips up to 50 miles per trip per calendar year.

Healthy at Home
Members experiencing homelessness or at risk of eviction can receive a one-time $500 benefit for housing assistance such as legal service, utility payments, government services, or minor home repair/weatherization.

Immunizations
Members can receive a $50 reward for completing the full series of childhood immunizations before their 2nd birthday, and members can receive a $50 reward for completing the adolescent immunizations before their 13th birthday.

Maternity and Newborn Benefits
In addition to pregnancy tests available via the over-the-counter benefit, members can earn Promise reward gift cards before and after their baby is born through the My Maternity Matters benefit:

The more visits they make to their doctor during their pregnancy, the more rewards they can get.

- $25 gift card for completing Notice of Pregnancy form in the first trimester and completing first prenatal visit
- $10 gift card for each additional prenatal visit, up to 10 visits ($100 maximum reward)
- $50 gift card for postpartum visit (within 7 to 84 days after delivery, must contact Member Services)
- Baby Bucks: Up to $50 to use towards items such as strollers, car seats, diapers, etc. (1/pregnancy)

The **My Maternity Companions** benefit also offers access to screenings, assessments, nutritional counseling, birth education and referrals to parental support programs for pregnant members and new mothers. Members can access up to 3 virtual prenatal visits, birth and after-birth classes, 3 virtual post-natal visits, 3 nutritional counseling sessions, and follow-up visits as needed.

Circumcisions are covered without the requirement of prior authorization up to 365 days of life. After 365 days, prior authorization is required.

Meals After an Inpatient Hospital Stay
Members receive two meals per day for up to 14 days post discharge for post-acute care. Eligibility restrictions apply.

Mobile App
With the Aetna Better Health application, our members can get on demand access to the tools they need to stay healthy and receive a $5 reward for downloading. It's easy. Member just downloads the app to their mobile device or tablet.

Mobile app features:

- Find a provider
- Request a Member ID card
- Change their PCP
- View their claims and prescriptions
- Message Member Services for questions or support
- Update their phone number, address, and other important member details

Download app: To get the mobile app, members can download it from Apple's App Store or Google's Play Store. Search for Aetna Better Health to locate the app. It is free to download and to use. This application is available on certain devices and operating systems (OS).

Nurse Line
Access to a nurse is available 24-hours a day, 7 days a week at **1-855-242-0802 (TTY: 711).**

Over-the-Counter (OTC) Medicine and Products
Members receive a $25 quarterly benefit per household for OTC vitamins and household and health products.

Pyx Program for Social Isolation
The program includes access to the Pyx app that provides 24/7 self-management and support. Members also have direct access to a Pyx Health staff who are trained to help support members one-on-one when they screen as lonely, depressed, anxious, or indicate any social determinant of health need.

Respite Care for Members Experiencing Homelessness
Members 18+ who were experiencing homelessness prior to hospitalization and are scheduled for discharge from an acute medical hospital with post-acute care needs can receive short-term room and board with wraparound health and social care services for up to 30 days. Members also receive care coordination and case management services, health education, medication management, chronic disease management support, and support from an ABHLA housing specialist.

Sickle Cell Medication Adherence
Members diagnosed with sickle cell anemia receive a $10 gift card after filling a prescription for a sickle cell-related medication, up to 2 incentives per year excluding pain medication

Smoking Cessation
Smoking cessation medications for up to six months and health coaching and phone counseling. Medications available for up to 6 months - Patch, gum, lozenge, nasal spray, inhaler, varenicline, bupropion. Identification of risk stratification through completion of the Health Risk Questionnaire, Outreach Assessment, and development of a member-centered Care Plan.

Utilization of educational resources such as mailings from Krames and active, one-on-one, engagement in development of a plan of care for any member willing to participate in the Care Management program to include Face-to-Face visits for any member in the Intensive Program. Available to members 18+ and 13+ with parental consent. Restrictions apply.

STI Screening
Members ages 16+ may receive $25 for completing all STI screenings (chlamydia, gonorrhea, and HIV).

Vision Benefits

Members do not need a referral to see an in-network vision provider. Members can find a vision provider in the provider directory online at **AetnaBetterHealth.com/Louisiana**. Aetna Better Health of Louisiana uses EyeMed for vision services. Members can call EyeMed at **1-888-747-0449 (TTY: 711)**, Monday through Saturday from 7 AM – 1 AM and Sunday 10 AM – 7 PM (Apr – Sep) or 7 MA – 1 AM (Oct – Mar) CST.

Covered services for adults 21 and over include a free annual eye exam through EyeMed and $125 toward eyewear (frames, glass, or contact lenses).

For members 21 and under, covered services include:

- A comprehensive eye exam interpreted by a licensed network optometrist or ophthalmologist
- A preventative vision screening performed by trained staff under the supervision of a licensed network vision provider
- Medically necessary screening, diagnosis, and treatment of eye and/or visual conditions
- Three pairs of eyeglasses per calendar year with no review required by the health plan
- Contact lenses deemed medically necessary when no other method can restore vision

Section 7: Benefit Overview Chart

Services covered by Aetna Better Health of Louisiana are described in detail in section 5 of this appendix. For easy reference, please see the chart below for a brief overview of services. Some limitations and prior authorization requirements may apply.

All services must be medically necessary. If you have questions about covered services, call Member Services at **1-855-242-0802,** TTY **711**. For specific criteria and prior authorization requirements, please see the **Utilization Management** section of the ABHLA provider website.

For a full, detailed list of services, see Section 5 of this Appendix. For Behavioral Health services in detail, see **Appendix B**. Pharmacy services are detailed in **Appendix C**. DME services are detailed in **Appendix D**. Transportation services are detailed in **Appendix E**. Adolescent services and programs such as EPSDT are detailed in **Appendix F**.

Behavioral Health Services are highlighted

Service/Benefit	Covered Service/Benefit	Limits
Allergy Testing and Immunotherapy	Allergy testing and immunotherapy relating to hypersensitivity disorders and for patients who have symptoms of allergic disease are covered.	Prior authorization is not required, but coverage limitations do apply.
Applied Behavior Analysis (ABA)	Behavior analysis is based on a scientific study of how people learn. By doing research, techniques have been developed that increase useful behavior (including communication) and reduce harmful behavior.	Covered for members from age 0-20. Prior authorization is required.
Basic behavioral health services	Services are provided in a primary care clinic and include screening for mental health and substance use issues, prevention, early intervention, medication management, treatment, and referral to specialty services.	Not limited by Aetna Better Health of Louisiana
Bariatric Surgery	Bariatric surgery is covered when determined to be medically necessary	Prior authorization is required. See Policy on ABHLA provider website for details.
Behavioral Health Home and Community Based Services-Adults	Assistance and support provided at home, school, or work. Additional services may be available for members with special mental health care needs. Includes Assertive Community Treatment (ACT), Crisis Intervention (CI), Community Psychiatric Support and Treatment (CPST), and Psychosocial Rehabilitation (PSR).	Covered for members eligible for adult mental health rehabilitation services. Prior authorization is required with the exception of emergent crisis intervention (CI).
Behavioral Health Home and Community Based Services-Children and Adolescents	Assistance and support provided at home, school, or work. Additional services may be available for members with special mental health care needs. Includes Assertive Community Treatment (ACT), Crisis	Covered for members from age 0-20. Age for specific services varies. Prior authorization is required with the

Service/Benefit	Covered Service/Benefit	Limits
	Intervention (CI), Functional Family Therapy (FFT), Homebuilders, Multi-systemic Therapy (MST), Community Psychiatric Support and Treatment (CPST), and Psychosocial Rehabilitation (PSR).	exception of emergent crisis intervention (CI)
Breast Pump	Covered for expectant mothers at 32 weeks gestational age who meet eligibility criteria	Prior authorization is not required. Providers must submit Electric Breast Pump Request Form with claim
Breast Surgery	Risk-reducing mastectomy and breast conserving surgery is covered when it is determined to be medically necessary.	Prior authorization is required (simple mastectomy is covered without prior authorization when determined to be medically necessary).
Cardiovascular Services	Elective Invasive Coronary Angiography (ICA) and Percutaneous Coronary Intervention (PCI) is covered when determined to be medically necessary.	For members 18 and over when medically necessary. For eligibility criteria, see Cardiovascular Services.
Cervical Cancer Screening	Covered for members 21 and over.	Covered for members under 21 when medically necessary. See Cervical Cancer Screenings.
Chiropractic Services	Medically necessary Chiropractic services when the service is provided as a result of a referral from an EPSDT medical screening provider or Primary Care Provider (PCP).	Covered for members of all ages, including 18 visits for adults aged 21+ as an in lieu of benefit. See *In Lieu of Services*.
Cochlear Implants	Includes: • Pre-operative speech and language evaluation • Implants, equipment, repairs, and replacements • Implantation procedure • Post-operative rehabilitative costs • Subsequent therapy (speech, language, hearing) • Re-performance of implantation surgery • Post-operative programming	Covered for members from age 0-20. Prior authorization required for all aspects of cochlear care. For more information, see Cochlear Implants.
Corneal Collagen Cross-Linking (CXL)	Medically necessary CXL and riboflavin 5'-phosphate, ophthalmic solution up to 3mL	Covered for members aged 14-20 with progressive keratoconus. Prior authorization is required. See CXL.
Continual Glucose Monitoring Device	Covered through the pharmacy benefit for members who meet certain criteria	Prior authorization is required.

Service/Benefit	Covered Service/Benefit	Limits
Community Health Workers	Includes: • Health promotion and coaching • Care planning • Health system navigation Additional requirements for CHW in Federally Qualified Health Centers and Rural Health Clinics	Covered for members with one or more of the following: • Diagnosis of one or more chronic health condition • Suspected/documented unmet health-related social need • Pregnancy
Crisis Response Services	Crisis resolution and support provided in the community available right away, twenty-four hours a day, seven days a week. Includes Mobile Crisis Response (MCR), Behavioral Health Crisis Care (BHCC), and Community Brief Crisis Support (CBCS).	MCR and CBCS are covered for all ages. BHCC is covered for members from age 21 and up. Prior authorization required for CBCS. A follow up is required within 24 hours.
Crisis Stabilization (Adult)	Short term, intensive, bed-based crisis support	Prior authorization is required. Members admitted to this level of care should be medically stable. Members who have a co-morbid physical condition that requires nursing or hospital level of care or who are a threat to themselves or others and require an inpatient level of care are not eligible.
Crisis Stabilization (Youth)	Short term, intensive, bed-based crisis support	Prior authorization is required.
Dental	After the first visit, you should see your dentist every six months.	Members 21 and over: Limit of$1,000 per year
Developmental and Autism Screening	Developmental and autism screenings administered during EPSDT preventive visits in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule	Limitations apply. See the Developmental Screenings section of Appendix F: Adolescent Services and Programs
Dialysis	Hemodialysis and peritoneal dialysis are covered for the treatment of End Stage Renal Disease (ESRD).	Prior authorization is required.
Disposable Incontinent Supplies	Covered for children ages 4-20 years old and adult members with the Home and Community Based Services Waiver (HCBS)	Prior authorization is required. Limit eight per day. See full policy for details
Disposable (Elastomeric) Infusion Pump	Covered for short term use (less than 30 days) for antibiotic infusion therapy	Prior authorization is required.
Durable Medical Equipment	Medical equipment, appliances, and supplies such as wheelchairs, bed rails, walkers, and crutches	Prior authorization is required. See Appendix D: Durable Medical Equipment

Service/Benefit	Covered Service/Benefit	Limits
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	Auditory osseointegrated device and supplies, cough stimulating device, hearing aids, pediatric hospital bed, standing frame/table system covered for age 20 and younger.	Not covered for Members 21 years of age or older. See Appendix D: Durable Medical Equipment
Early Periodic Screening, Diagnostic, and Treatment (EPSDT)/Well-Child Checkups	• Medical screenings • Developmental screenings • Vision screenings • Hearing screenings • Dental screenings • Periodic and inter-periodic Screenings	Covered for members age 0-20. See Appendix F: Adolescent Services and Programs
	School-Based Medical Program personal care services, which may include the following, depending on need: • Grooming • Eating • Transfers • Mobility • Positioning • Toileting • Behavioral cuing	Covered for members aged 0-20 in a school setting, when ordered by a licensed practitioner within the scope of their practice and the student is dependent in, and need assistance, for one or more of the activities of daily living (ADL).
Emergency Medical Services	ER (Emergency Room) services	
Emergency Medical Transportation	Ground and air ambulance including rotor- and fixed-wing	
End Stage Renal Disease Services (Dialysis)	Dialysis treatment (including routine laboratory services), medically necessary non-routine lab services, and medically necessary injections	
Enteral formula	Covered for beneficiaries who require formula to fulfill at least 70% of their caloric need and beneficiaries with known or suspected inborn errors of metabolism served by the OPH Genetic Disease Program.	For members of the Office of Public Health (OPH) Genetic Diseases Program, no PA is required. For all other patients, prior authorization is required.
Enteral Infusion Pump	Covered for members with one of the following conditions: • designated as “terminally ill” by a physician • Inborn errors of metabolism • Intellectual disability • Failure to thrive	Prior authorization is required. See Supplemental Nutrition Supplies section of Appendix D: DME
Family Planning Services	Covered in or out of network (no cost for out of network family planning). See Family Planning Services section for details.	Elective abortions are not covered.

Service/Benefit	Covered Service/Benefit	Limits
Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)	Professional medical and basic behavioral health services furnished by doctors (Primary Care Providers), nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists, licensed professional counselors, licensed marriage and family therapists, physicians with psychiatric specialties, and dentists.	Not limited by Aetna Better Health of Louisiana. See Community Health Workers section for details.
Gender Affirming Care	Prior authorization is required for all requests related to gender affirming care, surgery, or treatment including diagnosis codes F64.0-F64.9 & Z87.890	Not covered for members under age 18
Genetic Counseling	Required before and after all genetic testing. Reimbursed when performed by licensed genetic counselors using the procedure code 96040.	Covered for members aged 0-99 Maximum units = 3
Genetic Testing	Testing for BRCA1 and BRCA2 genetic mutations are covered in cancer-affected and -unaffected individuals meet eligibility requirements.	Not covered for members under age 19. See Genetic Testing section for details.
Hearing Aids	Hearing aids and related supplies such as earpieces and batteries	Not covered for members over age 21.
Home Health Services	• Skilled nursing services • Home health aide • Physical, occupational or speech therapy • Home infusion • Wound therapy • Extended Home Health (EHH) Services • Extended Skilled Nursing Services • Intermittent Nursing (IN) Services	Prior authorization is required. See Home Health Services section for details. For members 21+, only one visit per profession per day is covered. Covered for members birth through 20.
Hospice	Care provided by a certified hospice agency for terminally ill members.	Prior authorization is required. See Hospice section for details.
Hospital Bed, Mattress, And Lift	Covered for members with a documented medical need who meet medical necessity criteria. Each type of equipment requires specific documentation.	Prior authorization is required. See Appendix D: DME for details.
Human Donor Milk Outpatient	Covered for use by medically vulnerable infants when certain criteria are met.	Prior authorization is not required, but the service is subject to post payment medical review. See Appendix D: DME for details.

Service/Benefit	Covered Service/Benefit	Limits
Human Milk Storage Bags	Covered through DME benefit for lactating beneficiaries	Prior authorization is required. See Appendix D: DME for details.
Immunizations	Covered for members 0-20 Covered for members 0-18 via the Vaccines for Children (VFC) Program. Coverage for populations such as waivers programs, children not eligible for VFC, or for vaccines not provided by VFC. Some coverage for members 21 and up including flu, Human Papilloma virus (HPV), tetanus, and Pneumococcal polysaccharide vaccine (PPSV)	Limitations apply depending on member's age. See Appendix F: Adolescent Services and Programs for details
Individual Placement and Support (IPS)	Supported employment services for members with mental illness	Covered for members transitioned or diverted from nursing facility level of care through the My Choice Louisiana program. Prior authorization is required.
Inpatient Hospital Services	Inpatient hospital care needed for the treatment of an illness or injury that can only be provided safely and adequately in a hospital setting, including those basic services a hospital is expected to provide.	Prior authorization is required.
Intensive Outpatient Treatment (IOP)	Mental health and substance use treatment and recovery services provided in a community setting.	Prior authorization is required.
Lab tests and X-rays	Most diagnostic testing and radiological services ordered by the attending or consulting physician.	Prior authorization is required. For portable x-ray limitations, see Imaging section
Mammograms	Screening mammography, bilateral and Screening digital breast tomosynthesis, bilateral covered for Members aged 30 and up.	Not covered for Members under age 30. See Screening Mammography
Maternity Care Services	Prenatal through postpartum, including Obstetrical Ultrasounds, NIPT, and Tobacco Cessation Counseling.	
Mental Health Inpatient Hospital Services	Mental health services provided in the hospital	Prior authorization may be required.
Negative Pressure Wound Therapy (NPWT) Pump	One NPWT pump covered per month by any provider.	See Appendix D: DME for details.

Service/Benefit	Covered Service/Benefit	Limits
Non-Emergency Medical Transportation	Transportation to and from appointments for Medicaid covered services appointments and to extra services we offer such as adult dental care and pharmacy following a visit to your provider.	Services are scheduled through Meditrans Transportation Company and are not limited by Aetna Better Health of Louisiana. See Appendix E: Transportation for details.
Non-Invasive Prenatal Testing (NIPT)	NIPT is offered as a service to pregnant women over the age of 35, and to pregnant women of any age who meet one or more of the following high-risk criteria: • Abnormal first trimester screen, quad screen, or integrated screen. • Abnormal fetal ultrasound scan indicating increased risk of aneuploidy. • Prior family history of aneuploidy in first degree relative for either parent. • Previous history of pregnancy with aneuploidy. • Known Robertsonian translocation in either parent involving chromosomes 13 or 21.	NIPT is not covered for women with multiple gestations. For dates of service on or after 12/01/2020, CPT Codes 81507 and 81420 do not require prior authorization.
Nurse Midwife and Nurse Practitioner Services	Covered when performed in a doctor's office or clinic	
Nutritional/Dietician Consult Services	Nutritional consultation	Prior authorization is required. Not covered for members over age 21
Obstetrical Ultrasounds	All covered OB ultrasounds must be deemed medically necessary. Three (3) medically necessary ultrasounds per pregnancy (270 days) are covered without prior authorization or medical review. If additional studies are needed, prior authorization will be required. The following requirements also apply: • When an obstetric ultrasound is performed for an individual with multiple gestations, leading to more than one procedure code being submitted, this shall only be counted as one obstetric ultrasound; and • Obstetric ultrasounds performed in inpatient hospital, emergency department, and labor and delivery triage settings are excluded from this count.	For maternal fetal medicine specialists, there shall be no prior authorization or medical review required for reimbursement of obstetric ultrasounds. In addition, reimbursement for CPT codes 76811 and 76812 is restricted to maternal fetal medicine specialists. In all cases, obstetric ultrasounds must be medically necessary to be eligible for reimbursement.

Service/Benefit	Covered Service/Benefit	Limits
Opioid Treatment Programs (OTP)	Medication-assisted treatment for members with documented Opioid Use Disorder	Covered for members of all ages (under age 18 requires guardian consent when applicable). Prior authorization and referral is required.
Outpatient Therapy by Licensed Practitioners	Outpatient counseling for mental health and substance use treatment	No prior authorization is required. See Appendix B: Behavioral Health for a list of qualified providers.
Outpatient Services	Diagnostic and therapeutic outpatient services including outpatient surgery and rehabilitation services, therapeutic and diagnostic radiology services, chemotherapy, and hemodialysis. These services should be billed to Aetna Better Health in accordance with the Hospital Services Provider Manual.	Prior authorization may be required. Refer to the ABHLA Prior Authorization list or the Hospital Services manual for a list of services that require prior authorization.
Organ Transplant and Related Services	Evaluation, transplant, and facility costs are covered.	Donor costs are not covered. Prior authorization is required.
Oxygen: Portable Oxygen Contents	Covered for beneficiaries with a documented medical need	Prior authorization on a per-month basis is required. See Appendix D
Oxygen: Supplemental Oxygen and Oxygen Supplies	Covered for members with a documented medical need who meet medical necessity criteria. See Supplemental Oxygen policy on ABHLA provider website	Prior authorization is required. Prescribing provider must see the member within 60 days of prescribing oxygen therapy.
Pediatric Day Healthcare Services (PDHC)	Services include nursing care and assessments, medication administration, wound care, supervised feeding, respiratory care, physical therapy, speech therapy, occupational therapy, assistance with aids of daily living, transportation services, and education and training. Nursing care services and therapy provided in a central location during the day, up to 12 hours per day up to 7 days a week.	Covered for members up to 21 years when medically necessary. Prior authorization is required. See the PDHC section
Personal Care Services (PCS)- Behavioral Health	Assistance and supervision for members with mental illness to allow them to complete activities of daily living and live independently.	Covered for members transitioned or diverted from nursing facility level of care through the My Choice Louisiana program. Limit of 20 hours/week. Prior authorization is required.
Personal Care Services (PCS) – Early and Periodic Screening Diagnostic and	Assistance and supervision for members with physical disabilities to assist with completing activities of daily living and live independently	Prior authorization is required. Providers must submit hours per day and days per week with the authorization request. This is translated to an authorization service

Service/Benefit	Covered Service/Benefit	Limits
Treatment (EPSDT) Physical Health		code that is loaded into the EVV system. Providers may only clock the hours approved in the request. Hours may not be moved from one day to the next. Providers must clock in the LaSRS EVV system as directed by LDH. ABHLA must withhold or deny reimbursement for services if a PCS provider fails to utilize the EVV system. Providers must be registered with LDH.
Peer Support	Support from people with the same experiences. This includes but is not limited to experiences living with a mental illness or substance use disorder or caring for a child with a mental illness or substance use disorder.	Prior authorization is required
Perinatal Depression Screening	ABHLA covers perinatal depression screening administered to any member's caregiver in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule.	The screening can be administered from birth to 1 year during an Early and Periodic Screening, If 2 or more children under age 1 present to care on the same day (e.g., twins or other siblings both under age 1), the provider must submit the claim under only one of the children. When performed on the same day as a developmental screening, providers must append modifier -59 to claims for perinatal depression screening.
Pharmacy Services	Prescription medications that are on our formulary For a complete list of meds and/or to review the formulary, please visit **www.AetnaBetterHealth.com/Louisiana**.	Quantity limits, step therapy, and prior authorization may be required. See Appendix C
Physician-administered drugs	See Appendix C: Pharmacy	Prior authorization may be required regardless of setting.
Physician/Professional Services	Professional medical services including those of a physician, nurse midwife, nurse practitioner, clinical nurse specialists or physician assistant.	Prior authorization may be required.

Service/Benefit	Covered Service/Benefit	Limits
Podiatrist Services	Office visits, certain radiology and lab procedures and other diagnostic procedures.	Prior authorization may be required.
Psychiatric Residential Treatment Facilities	Allows youth to live in a treatment facility to get the behavioral health care needed	For members under age 21. Prior authorization is required.
Psychiatrist Visits	Visits with a licensed psychiatrist. A psychiatric nurse practitioner is also able to provide this service.	No prior authorization required
Radiology Services	Most diagnostic testing and radiological services ordered by the attending or consulting physician.	Only CT scans and MRI's require prior authorization. See Imaging section
Rehabilitation Services	Short term stays in a long-term care nursing facility for the purposes of rehabilitation.	Prior authorization is required.
Respiratory Viral Panels	CPT codes 87631, 87632, and 87633 are covered	Medical necessity is required. See Respiratory Viral Panels
Substance Use Rehabilitation Services	Outpatient, Inpatient, and residential counseling and treatment for substance use conditions.	Prior authorization may be required.
Sedation Services	Moderate (conscious) sedation services are covered for members 20 and under.	Not covered for members aged 21 and over.
Sexually Transmitted Disease (STD) Services	Testing, counseling and treatment of all STDs and confidential HIV testing	
Sinus Procedures	Balloon ostial dilation and functional endoscopic sinus surgeries are covered when certain criteria are met. See coverage criteria in Sinus Procedures	Coverage limitations do apply. Reimbursement is subject to post-payment review and recoupment in the event of non-compliance with the coverage policy.
Skin Substitutes	Covered for patients with Chronic Diabetic Lower Extremity Ulcers. See coverage criteria in Skin Substitutes.	Prior authorization is required Documentation must demonstrate that the beneficiary meets all requirements.
Telemedicine for Behavioral Health Services	An alternative to clinic visits for members that have barriers to in-person behavioral health services. Meet with your behavioral health providers from a computer.	

Service/Benefit	Covered Service/Benefit	Limits
Sterilization / Hysterectomy	For reimbursement, Sterilization and Hysterectomy procedures require receipt of a state-approved consent form properly executed per state requirements, and on the applicable fee schedule or contracted/negotiated rate. ABHLA allows ancillary providers and hospitals to submit claims without the hard copy consent if the provider performing the sterilization has submitted a valid sterilization consent and was reimbursed for the procedure.	Members must be at least 21 years old at time the consent is obtained, must be a mentally competent individual, who has voluntarily given informed consent in accordance with all federal requirements. At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.
Therapeutic Day Treatment	Provides intensive mental health supports combined with classroom instruction as an alternative to crisis hospitalization and residential psychiatric care for youth with behavioral, emotional, or mental health issues.	For members ages 5-20. Prior authorization is required.
Therapeutic Group Homes	Allows youth to live in a home-like setting with a small group of other youth to get the services needed	For members under age 21. Prior authorization is required.
Therapy Services	Occupational, physical, speech, and language	Prior authorization is required. Renewal Therapy request should show progress.
Tobacco Cessation Counseling (including during pregnancy)	Counseling to help Members (including pregnant individuals) quit tobacco use. Must be provided by PCP, OB, or a professional referred by PCP or OB.	Up to 4 sessions per quit attempt Up to 2 quit attempts per calendar year Maximum of 8 sessions/yr Limits may be exceeded if deemed medically necessary Covered during prenatal period through 60 days postpartum for pregnant individuals
Transcranial Magnetic Stimulation (TMS)	Covered for major depression when medically necessary.	Medical necessity is required.

Service/Benefit	Covered Service/Benefit	Limits
Urine Drug Screening	Presumptive and definitive screenings	Limits and stipulations apply. See Urine Drug Screening
Vision Services	Adults 21 and over: Your covered services include optometrist services, a free annual eye exam, and $150 toward eyewear (frames, glass, or contact lenses). Members 21 and under: Covered services include: • A comprehensive eye exam interpreted by a licensed network optometrist or ophthalmologist • A preventative vision screening performed by trained staff under the supervision of a licensed network vision provider • Medically necessary screening, diagnosis, and treatment of eye and/or visual conditions • Three pairs of eyeglasses per calendar year with no review required by the health plan • Contact lenses deemed medically necessary when no other method can restore vision	Certain limits apply. Prior authorization may be required.