

Provider Update

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National Drug Code (NDC) Implementation

NDC Information Required on Claim Submissions for Physician-Administered Drugs

A federal statute outlined in the Deficit Reduction Act of 2005 and enacted in January 2008 mandates that providers must begin reporting National Drug Code (NDC) information on claim submissions for all physician-administered drugs.* This requirement applies to both electronic and hard copy Medicaid claims and affects physicians, physician groups, APRNs, physician assistants, as well as outpatient hospitals and licensed hemodialysis centers. For additional information related to this implementation, providers should review earlier notices posted on the Louisiana Medicaid web site: www.lamedicaid.com.

Because of implementation difficulties for the provider community, the mandate to deny claims was postponed, and educational edits have continued to be utilized in order to allow time for providers to develop processes to collect and report the required data.

Effective with processing date April 1, 2009, claims for professional services, outpatient hospital services and hemodialysis services will be denied if the claim forms do not contain accurate NDC information. The educational edits utilized during the grace period will become denial edits for professional services, outpatient hospital, and hemodialysis claims.

These edits are:

Edit 120 - "Quantity Invalid/Missing"

Edit 127 - "NDC Missing or Incorrect"

Edit 231 - "NDC Not on File"

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Current claims history indicates that many claims continue to be submitted with the required data either missing or entered incorrectly on the claim. Once these edits become denial edits, any claims with incorrectly entered data will deny. Please review the entry of this information and ensure that it is correct and complete.

Claims for any Medicaid covered service which includes a physician-administered drug must be accompanied by the actual NDC from the package of the drug administered and other required information. The information must be entered on the claim form (electronic or hardcopy) EXACTLY as indicated in the billing instructions to prevent claim denials.

Billing instructions for the CMS-1500 form and the UB-04 form are posted on the LA Medicaid web site, www.lamedicaid.com, under the Billing Information link. The LA Medicaid EDI Companion Guides for the 837P and 837I were revised to include this information for EDI billing and the revisions were made available on the web site under the link, HIPAA Billing Instructions and Companion Guides.

Providers, vendors, billing agents, and clearinghouses must update their billing systems to accommodate this mandate.

Rural Health Clinics, Federally Qualified Health Centers, and Mental Health Clinics are **not** included in the implementation of this mandate.

This change **does not include** prescriptions written for patients by physicians. The information required in these cases will be reported by the pharmacy filling the prescription for the patient. Please consult your clinical professionals if you have questions concerning drugs that should have NDC information reported, as it will be present on the packaging of the drug.

On-line provider training sessions or Webinars concerning this implementation were held in early February for affected providers. The training presentation is posted on the LA Medicaid web site, www.lamedicaid.com, link Training, link 2009 Training Materials, for providers that were unable to attend these sessions. Please ensure that you have reviewed this material in preparation for the April 1st implementation date.

** Physician-administered drugs include all drugs ordered by any professional with authority to write prescriptions, regardless of which clinical professional actually administers the drug.*

NEW PROVIDER DATABASE: Action Required

The Department of Health and Hospitals (DHH) has implemented a new database to capture ownership information for all providers. This is a secure database where all ownership information will be maintained on Medicaid providers.

Who is required to enter ownership information?

All enrolled Medicaid providers, and those seeking enrollment in Louisiana Medicaid, must furnish ownership information to DHH. This includes individuals as well as entities (businesses).

How do I enter ownership information?

To utilize the web-based application, log on to www.lamedicaid.com and select the "Provider Enrollment" link under "Provider Login." Then select the "Applications for New Enrollments, Reactivations and Change of Ownership" link, and select "here" under Option 1.

The "Provider Ownership Enrollment" screen will open and you will need to click "I Agree" and proceed as directed. It will only take a few minutes to complete the entry; however, if the system is idle for 20 minutes, it will timeout and any information entered will be lost.

What information do I need to enter?

Before beginning the ownership registration process, it is recommended that you gather the following information for each provider, owner, and manager for your organization.

Provider

1. Enrollment Type - individual (person) or entity (other)
2. Current Enrollment Status - new enroll, re-enroll/change of ownership (CHOW) or currently enrolled
3. Legal Type - Corporation, LLC, Sole Proprietorship, etc.
4. Social Security Number
5. EIN (Taxpayer Id Number)
6. Doing Business As (DBA) Name
7. Full Name
8. Provider Type
9. Louisiana Medicaid Provider ID (if available)
10. National Provider Identifier (if applicable)
11. Provider information relating to
 - criminal offenses
 - disciplinary actions
 - denial of enrollment in any other health plan

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12. Information relating to other government health plan(s) in which the provider may participate
 - health plan name
 - identification number
 - issuing state

Owners - Information relating to each individual or organization that holds a 5% or greater ownership interest in this provider

1. Owner's Full Name (individual or organization)
2. Doing Business As (DBA) Name
3. Legal Type of Owner - Corporation, LLC, Sole Proprietorship, etc.
4. Owner's Social Security Number and/or EIN (Taxpayer ID Number)
5. Public/Private Status
6. Information relating to
 - criminal offenses
 - disciplinary actions
 - denial of enrollment in any other health plan(s) for each owner
7. Information relating to any other government health plan(s) in which the owner may participate
 - name
 - identification number
 - issuing state

Management - Information on each individual identified as part of the provider's management structure including senior management or those who have direct management responsibility for the organization

1. Full Name
2. Social Security Number
3. Title
4. Information relating to
 - criminal offenses
 - disciplinary actions
 - denial of enrollment in any health plan

What if I do not have internet access?

If internet access is unavailable, the forms may be requested from Unisys Provider Enrollment by calling (225) 216-6370 or by mail at P O Box 80159, Baton Rouge, LA, 70898-0159.

When should I enter this information?

This information should be entered as quickly as possible and updated any time a change in ownership or management occurs.

All Providers

PROVIDER WARNING: Avoid Hiring an Excluded Individual

As a condition of participation in the Louisiana Medicaid Program, all Medicaid providers are responsible for ensuring that a current or potential employee has not been excluded from participation in the Medicaid or Medicare program by the Office of Inspector General (OIG).

Individuals may be excluded from participation for various reasons, including convictions of Medicaid or Medicare program related crimes, convictions related to patient abuse or neglect, or felony convictions for health care fraud or controlled substance offenses.

A provider may be held responsible for refunding Medicaid for the claims paid for services which were provided by an excluded individual. Providers may also be subject to penalties of \$10,000 for each item or service furnished by an excluded individual and/or damages for the amount claimed in each item or service.

Both the <http://exclusions.oig.hhs.gov/search.aspx> and <http://www.epls.gov/epls/search.do> websites must be checked to avoid hiring an excluded individual. In addition, these websites should be checked periodically to determine the exclusion status of current employees.

If a current or prospective employee's name is listed on one or both of these databases, the findings should be reported to the Department of Health and Hospitals (DHH) and should include:

- Your Medicaid provider name (individual or business entity) and Medicaid provider number,
- Your business address and contact telephone number,
- The name of the excluded employee,
- Status of the individual (applying for employment or currently employed),
- Documentation of termination of employment, if the individual was an employee,
- The period of the individual's employment with your agency, and
- The type of service(s) provided by the excluded individual.

This information is to be faxed or mailed to the following address:

Department of Health and Hospitals
Program Integrity - Special Investigations Unit
P. O. Box 91030
Baton Rouge, LA 70821-9030
(225) 219-4155

When DHH is notified that an excluded individual has been employed by a Medicaid provider, DHH must notify the Office of Inspector General's Fraud Section, Prevention and Detection Program.

Medicaid providers should review the information provided in the SPECIAL ADVISORY BULLETIN titled "The Effect of Exclusion from Participation in Federal Healthcare Programs" at <http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/effected.htm>.

Sections E, F, and G of the bulletin explain the prohibition against hiring excluded individuals and the fines and penalties involved when an excluded individual is hired.

All Providers

2009 HCPCS Status Update

The Louisiana Medicaid files have been updated to reflect the new and deleted Healthcare Common Procedure Coding System (HCPCS) codes for 2009. Appropriate editing and coverage determinations for the new codes are still underway along with systematic adjustments for some previously processed claims. Providers will be notified when these changes have been completed, and no action is required by providers. The 2009 Current Procedural Terminology (CPT) manual includes information on the appropriate reporting of the new codes. It is the intent of Louisiana Medicaid that these instructions be followed. All payments are subject to post payment review and recovery of overpayments.

Reporting Medicaid Fraud

Providers of Medicaid services should report suspected cases of abuse of Medicaid services or recipient fraud to the Program Integrity office. These reports can be made by

- Calling the Medicaid Fraud Hotline at 1-800-448-2917, or
- Submitting a completed Recipient Fraud Form when you log on to <http://www.dhh.state.la.us/offices/fraudform.asp?id=92>

Reports can also be made by downloading the Recipient Fraud Form at the above website and either faxing or mailing it to

Department of Health and Hospitals - Program Integrity
P. O. Box 91030
Baton Rouge, LA 70821-9030
Fax # (225) 219-4155

Dental Providers

Dental Program Changes

Dental providers should be aware of several changes in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and other dental programs within the last two months.

Effective December 12, 2008 the following restorative procedures were added to the EPSDT Dental Program:

- D2391 Resin-based composite, one surface, posterior**
- D2392 Resin-based composite, two surfaces, posterior**
- D2393 Resin-based composite, three surfaces, posterior**
- D2394 Resin-based composite - four or more surfaces (posterior)**

Each of these procedures represents a final restoration and is reimbursable for Tooth Numbers 1 through 5, 12 through 16, 17 through 21, and 28 through 32; and, Tooth Letters A, B, I, J, K, L, S, and T. These procedures do not require Prior Authorization.

If two restorations are placed on the same tooth, a maximum fee for resin-based composites that can be reimbursed per tooth has been established. The fee for any additional restorative service(s) on the same tooth will be reduced to the maximum fee for the combined number of surfaces when performed within a 12-month period.

The resin-based composite - four or more surfaces (D2394) is a single posterior restoration that involves full resin-based composite coverage of a tooth. Providers may bill this procedure in cases where two D2393 restorations would not adequately restore the tooth.

All composite restorations must be placed in a preparation that extends through the enamel and into the dentin. To bill for a particular surface in a complex restoration, the margins of the preparation must extend past the line angles onto the claimed surface. A Class V resin-based composite restoration is a one-surface restoration.

In addition, the following oral surgery procedure was added to the EPSDT Dental Program:

D7111 Extraction, Coronal Remnants - Deciduous Tooth

This code is defined as the removal of soft tissue-retained coronal remnants for deciduous teeth only. This procedure code is reimbursable for Tooth Letters A through T and AS through TS and does not require Prior Authorization.

Dental Providers (cont.)

FEE INCREASES

Numerous fees in the EPSDT Dental Program will be increased in keeping with the legislative mandate to provide reimbursement at a rate equal to 75% of the 70th Percentile of the National Dental Advisory Service Comprehensive Fee Report. Contingent upon approval from the Centers of Medicare and Medicaid (CMS), reimbursement rates for these fees will be increased for dates of service on or after December 24, 2008. Providers who bill their usual and customary fee will not be required to manually adjust their claims.

In addition, certain dental procedure codes in the EDSPW Program will be increased effective for dates of service on and after January 6, 2009 pending CMS approval. Affected claims will be recycled by Medicaid with no action required by providers.

Providers are reminded to check the Medicaid website at www.lamedicaid.com regularly for information and updates.

EarlySteps Providers

Reimbursement Rates for Selected Services Updated

Effective with date of service September 1, 2008, reimbursement rates for selected EarlySteps services provided in the Natural Environment have been updated. The updated rates can be found on the EarlySteps Fee Schedule located on the Medicaid website, www.lamedicaid.com following the Fee Schedules link. Affected claims paid at the previous rate will be systematically adjusted in the near future if the billed charges were greater than the previous fee on file. No action will be required by providers. Please monitor your Remittance Advices for the specific date(s) the adjustments will take place.

Department of Health and Hospital's policy states providers are to enter their usual and customary charges for services rendered. Claims where the billed charges were less than or equal to the previous fee on the file will not be included in this systematic adjustment. For this situation, if providers determine adjustments are needed, providers should review the claim adjustment policy and procedures in the 2007 Louisiana Medicaid EarlySteps Provider Training manual, pages 31-36. Please contact Unisys Provider Relations at (800) 473-2783 if you have any questions.

Home and Community Based Service Providers

Direct Service Worker Training Curriculum Available for Home and Community Based Service Providers

Act 306 of the 2005 Regular Legislative Session directed the Department of Health and Hospitals (DHH) to establish and maintain a registry for direct service workers. A direct service worker (DSW) is an unlicensed person who provides personal care or other services and support to persons with disabilities or to the elderly to enhance their well-being and which involves face-to-face direct contact with the person. The registry maintains the names of individuals who either by work history or training are eligible to be registered in Louisiana as a direct service worker. The registry also allows potential employers to determine if the worker is in good standing and that there are no findings of abuse, neglect, misappropriation or exploitation against them. A final rule outlining training requirements for direct service workers was published in the November 20, 2006 *Louisiana Register*. The provider types licensed by DHH that are affected by registry requirements include Intermediate Care Facility/for Persons with Developmental Disabilities (ICF/DD), Personal Care Attendant (PCA), Supervised Independent Living (SIL), Respite, Adult Day Care (ADC) and Adult Day Health Care (ADHC). The rule requires direct service workers to complete a basic 16 hour training curriculum and successfully pass a competency evaluation in order for their name to be entered on the direct service worker registry.

Providers have been allowed to develop their own training curriculums as long as all nine core requirements specified by the rule are included, and the curriculum is approved by DHH Health Standards. This process has proven to be burdensome and time consuming for both providers and Health Standards. In an effort to facilitate getting workers trained and on the registry, Health Standards has developed a training curriculum, and it is available to providers on their web site at <http://www.dhh.state.la.us/offices/?ID=112>. Providers, who are not approved to conduct training and wish to use the Health Standards training curriculum, need to send the following documentation to Health Standards:

- a letter of intent stating they plan to use the training curriculum,
- a copy of the course objectives, and
- the qualifications of the individual designated as the training coordinator for their program.

Providers were previously notified that Medicaid reimbursement may be affected if compliance with DSW training requirements is not achieved. In consideration of this possibility, providers need to look at the most expedient means available to get their workers trained. Options include contracting with an approved agency or school, purchasing an approved training curriculum or utilizing the Health Standards training curriculum.

Questions may be directed to the DSW Registry staff at (225) 342-5794.

Nursing Home Providers

Bed Buy-Back (Fair Rental Value, Property Tax and Property Insurance Incentive Payments to Buyers of Nursing Facilities) and Private Room Conversion Incentive Payments

Louisiana Medicaid established procedures for nursing facilities who participate in Medicaid to take part in incentive payments available to buyers or current owners of nursing facilities for either fair rental value, property tax and property insurance (bed buy-back), or private room conversion. Nursing facilities now have the opportunity to receive incentive payments when closing nursing homes or converting semi-private rooms to Medicaid-occupied private rooms.

Bed Buy-Back

Facilities qualifying for bed buy-back incentive payments must comply with the following requirements in addition to providing the usual documentation already required by Health Standards or other divisions related to change of ownerships, admissions and discharges. The required documentation must be submitted to the Department of Health and Hospitals, Rate and Audit Review Section.

Required Documentation

1. Qualified buyer(s) must submit the following documentation in writing no later than 30 days after the legal transfer of ownership:
 - a list of all buyers;
 - a list of all sellers;
 - the date of legal transfer of ownership;
 - each buyer's percentage share of the purchased facility; and
 - each buyer's current nursing facility resident listing and total occupancy calculations as of the date of the legal transfer of ownership.

2. Qualified buyer(s) must submit all of the following documentation in writing no later than 110 days after the legal transfer of ownership:
 - A list of the nursing facility residents that transferred from the seller facility and were residents of the buyer facility as of 90 days after the legal transfer or ownership date. The nursing facility resident list must include the payer source for each resident.
 - The date the seller's facility was officially closed and no longer operating as a nursing facility.

Nursing Home Providers (Cont.)

Incentive Payment Calculations

1. The total annual Medicaid incentive payment (base amount) for each transaction will be calculated in accordance with the provisions outlined in the June 20, 2008 Rule.
 - The payment amount that corresponds to the cumulative occupancy increase (including both Medicaid and non-Medicaid residents) for all buyers and the number of beds surrendered will be multiplied by each buyer's percentage share in the transaction. The result will be each buyer's annual Medicaid incentive payment for five years.
 - The base capital amount will be trended forward annually (July 1) to the midpoint of the rate year using the change in the per diem unit cost listed in the three-fourths column of the R.S. Means Building Construction Data Publication, adjusted by the weighted average total city cost index for New Orleans.
2. Buyer's fair rental value, property tax, and property insurance per diems will be re-based retroactive to the date of closure of the purchased facility.

The number of total resident days used in the calculation of each buyer's current fair rental value per diem will be increased by the number of residents the buyer acquired, multiplied by the number of current rate year days.

3. The per diem will be calculated as the buyer's annual Medicaid incentive divided by annual Medicaid days.

Annual Medicaid days will be equal to Medicaid residents transferred from the seller facility multiplied by 365 days, plus the buyer's Medicaid days from the most recent base year cost report (annualized in the case of a short base year cost report).

Private Room Conversion

Nursing facilities participating in the Louisiana Medicaid Program are eligible to receive an additional \$5 per diem incentive payment through the private room conversion initiative. Nursing facilities interested in participating in the conversion of semi-private rooms to Medicaid-occupied private rooms must comply with the following requirements.

Qualifying Facilities

1. In order for a nursing facility's beds to qualify for an additional \$5 per diem payment, the revised square footage per bed, a revised property tax pass-through and a revised property insurance pass-through, the following conditions must be met:
 - The nursing facility must convert one or more semi-private rooms to private rooms on or after September 1, 2007.

Nursing Home Providers (Cont.)

- The converted private rooms must be occupied by Medicaid residents to receive the \$5 incentive payment.
 - The nursing facility must surrender their bed licenses equal to the number of converted private rooms.
2. The nursing facility must submit the following information to the Health Standards Section 45 days prior to effective date of the bed change:
- a letter stating the facility's intent to do a private room conversion;
 - a floor plan indicating the room numbers involved;
 - the effective date of bed change, which must occur on 1st day of their cost reporting quarter (only one bed decrease request per cost reporting year can occur); and
 - the license application with the applicable fee.
3. The nursing facility must submit the following information to the Rate and Audit Review Section within 30 days of the private room conversion:
- the number of rooms converted to Medicaid private rooms;
 - the number of beds de-licensed in the conversion of the private rooms;
 - a resident listing by payer type for the converted private rooms that includes the date that each patient was placed in the private room;
 - the date of the actual conversions in license; and
 - a copy of revised license when received from Health Standards.

Note: Rate and Audit Review will receive notification from Health Standards which will serve as notification of license change until such time that the provider is able to obtain and forward the new license to Rate and Audit Review.

Incentive Payment

1. The nursing facility will bill using **Revenue Code 119** for the number of days the Medicaid recipient occupied the private room.
2. The additional \$5 per diem payment determination will be as follows:
 - An additional \$5 will be added to the nursing facility's case-mix rate for each Medicaid resident day in a converted private room. (The facility will not be reimbursed the additional \$5 for those days that the recipient is absent from the facility due to hospital or home leave).
 - The payment will begin the first of the following calendar quarter, after the facility meets all of the qualifying criteria.
 - A change in ownership, major renovation, or replacement facility will not impact the \$5 additional per diem payment provided that all other provisions of the August 20, 2007 Rule have been met.

Nursing Home Providers (Cont.)

Square Footage Adjustment:

1. The increase in the allowable square footage under the case-mix fair rental value calculation will be determined as follows:
 - After a qualifying conversion of semi-private rooms to private rooms, the nursing facility's square footage will be divided by the remaining licensed nursing facility beds to calculate a revised square footage per bed.
 - Allowable square footage will be determined as follows:
 - There will be no change in total square footage if no other facility renovations or alterations changing square footage occurred immediately prior to the private room conversion.
 - The square footage is determined as if the private room conversion did not occur if a change in total nursing facility square footage occurs for an existing building concurrent with, or subsequent to, a private room conversion.
 - Square footage changes due to new buildings will have their allowable square footage calculated as usual.
 - Resident days used in the fair rental value per diem calculation will be the greater of the annualized actual resident days from the base year cost report or 70% of the revised annual bed days available after the change in licensed beds.
 - A new fair rental value per diem will be calculated using the revised allowable square footage, remaining licensed beds, and the revised minimum occupancy calculation.
 - The revised fair rental value per diem will be effective the first of the following calendar quarter, after the facility meets all qualifying criteria.

If additional information is required, please contact the Rate and Audit Review Section at (225) 342-6116.

Web Based Reporting System Mandatory for Nursing Homes

The November 20, 2008 publication of the Louisiana Register included amendments to minimum licensing standards for nursing homes related to the reporting of abuse, neglect and misappropriation of property/funds and suspicious death. Nursing homes will now be required to utilize the Department of Health and Hospitals (DHH) Online Tracking Incident System (OTIS) to report these incidents. Facilities are required to have internet access and insure that the DHH Health Standards' Nursing Home Program has the administrator's current e-mail address.

During the month of February, facilities were given the opportunity to utilize the OTIS test site on the Health Standards website, and training opportunities will be available on the use of OTIS during the months of March and April. Health Standards will be notifying facilities about the scheduled training dates, and facility administrators and their staff are encouraged to take advantage of the training. A date for mandatory reporting through OTIS will be announced after training has been completed.

Louisiana Drug Utilization Review Education

Syphilis, Gonorrhea, and Chlamydia: A Review of Recommended Treatment Guidelines

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Sexually transmitted diseases are problematic for both the State of Louisiana as well as the rest of the United States. Each year, according to the Centers for Disease Control (CDC), about nineteen million new cases of sexually transmitted diseases (STDs) are reported. Close to half of these new cases were reported in patients between the ages of fifteen and twenty four. In addition to being costly, STDs may also negatively affect patients' lives socially as well as lead to reproductive consequences including fertility complications, pelvic inflammatory disease, and ectopic pregnancy¹. Over twenty STDs which may be caused by either a virus or bacteria exist. Syphilis, gonorrhea, and chlamydia are three sexually transmitted bacterial infections which must be reported by a practitioner when a diagnosis is made.² An overview of pharmacologic treatments for these three notifiable sexually transmitted infections (STIs) will be discussed in this article. Treatment guidelines for non-Human Immunodeficiency Virus (HIV) infected adults are highlighted in this overview. Refer to the full guidelines for complete treatment information and follow-up recommendations available at <http://www.cdc.gov/std/treatment/>.

Syphilis is a sexually transmitted genital ulcerative infection. This infection can present in one of three phases, primary, secondary, or tertiary. This infection is caused by the spirochete, *Treponema pallidum* subspecies *pallidum*.^{3,4} Although the infection rate of primary and secondary syphilis declined during the 1990's and the lowest reported infection rate was attained in 2000, the national rate of syphilis infections increased 13.8 percent between 2005 and 2006.⁵ During 2006, 342 cases of syphilis were reported in Louisiana, leading to Louisiana being ranked second among the fifty states, Washington, DC, and three other territories.⁶ Serious consequences of untreated syphilis include brain, cardiovascular, and organ damage and death. The Centers for Disease Control (CDC) recommends treatment with parenteral penicillin G for all phases of syphilis. Interestingly, the efficacy for this recommendation is not based upon evidence exhibited in clinical trials, but on the opinion of those knowledgeable about STDs. Although this recommendation has been supported through case series, clinical trials, and fifty years of clinical experience, comparative studies to evaluate dose, duration of treatment, or preparation do not exist.² Patients with primary syphilis usually present with a genital ulcer referred to as a chancre. This chancre is typically a painless, indurated ulcer which typically occurs at the site of inoculation. The ulcer usually appears after an incubation period of approximately three to ninety days.⁴ Due to variation in presentation of the disease, serologic tests should be used to diagnose early syphilis.^{2,4} It is often difficult to differentiate between primary and secondary syphilis. Although primary lesions may have healed by the time a patient presents with secondary syphilis, as many as one-third of patients will still have a primary chancre present. However, over half of patients diagnosed with syphilis do not remember having lesions present.

Louisiana Drug Utilization Review Education

Other clinical manifestations of secondary syphilis include rash, fever, malaise, lymphadenopathy, mucus lesions (more commonly present in women), alopecia, asymptomatic meningitis, and headaches.⁴ Patients with either primary or secondary syphilis should be given an intramuscular injection of 2.4 million units of benzathine penicillin G. The CDC recommends doxycycline 100 mg by mouth twice daily for two weeks or tetracycline 500 mg four times daily for two weeks in non-pregnant patients with an intolerance to penicillin. Of these two regimens, doxycycline may be the best option to optimize compliance due to a decreased pill burden and less gastrointestinal adverse effects. The CDC guidelines also mention 1 gram of ceftriaxone once daily either intramuscularly or intravenously for eight to ten days yet limited evidence supports the efficacy of this regimen.² A pilot study performed in Tanzanian patients evaluating azithromycin 2 grams by mouth as a one time dose suggests azithromycin may be another alternative. This study occurred in East Africa, therefore results may not be applicable to patients in the United States due to a difference in geographical resistance patterns. Resistance with azithromycin is a concern because reports of macrolide resistant *T. pallidum* exist in the United States.⁷ A randomized controlled, multicenter equivalence study with sites in Louisiana, Alabama, Indiana, North Carolina, and Madagascar concluded that in HIV negative patients, 2 grams of azithromycin by mouth had similar serological cure rates when compared to 2.4 million units of benzathine penicillin G given intramuscularly for the treatment of early syphilis. Limitations of the study include only 21% of the study participants were located at sites in the US and no data regarding resistance were collected.⁸ The results of this study have not been endorsed by the CDC. Pregnant patients with an allergy to penicillin should not be treated with either doxycycline or tetracycline because both of these medications have the potential to cause fetal harm in pregnancy. In addition to doxycycline and tetracycline being classified as pregnancy category D, penicillin is preferred because of its proven efficacy in preventing maternal transmission of syphilis to the fetus. The CDC recommends pregnant patients with a penicillin allergy be desensitized to penicillin and then administered the appropriate dose of penicillin corresponding to the stage of syphilis.² Tertiary syphilis, which occurs years after the initial infection, encompasses gumma and cardiovascular syphilis. In gumma syphilis, granulomatous-like lesions can cause local destruction in any organ, with the skin, mucous membranes, and bones being most commonly affected. Cardiovascular syphilis occurs when elastic tissue of the aorta is damaged.³ The treatment for tertiary syphilis is 2.4 million units of penicillin G benzathine intramuscularly once weekly for three weeks. Alternative regimens in non-pregnant patients with a penicillin allergy include 100 mg of doxycycline by mouth twice daily or 500 mg of tetracycline four times daily for four weeks.² During every stage of syphilis the possibility for central nervous system involvement, or neurosyphilis, exists. Clinical manifestations of neurosyphilis include seizures, ataxia, aphasia, impaired movement, hyperreflexia, cognitive changes, changes in vision or hearing, neuropathy, and loss of bowel and bladder functions.^{2,3} The treatment for neurosyphilis is 3 to 4 million units of aqueous crystalline penicillin G given intravenously every four hours or 18 to 24 million units per day given as a continuous infusion for ten to fourteen days. If compliance can be guaranteed, an alternative regimen may be used. This alternative regimen consists of an intramuscular injection of 2.4 million units of procaine penicillin once daily in addition to probenecid 500 mg by mouth four times per day. Treatment with both drugs should be continued for a total of ten to fourteen days.

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Although the possibility of cross-reactivity exists with ceftriaxone and penicillin, patients with an allergy to penicillin may seek treatment with 2 grams of ceftriaxone daily either intramuscularly or intravenously for 10-14 days. For patients in which ceftriaxone therapy is not an option and in pregnant patients with an allergy to penicillin, desensitization to penicillin is recommended.

Gonorrhea is an STI caused by the gram negative organism, *Neisseria gonorrhoeae*.^{2,9} Even though this STI is the second most commonly reported notifiable disease in the United States, with more than 350,000 cases of gonorrhea reported during 2006 in the US, it is thought that about twice as many infections exist than the number reported.⁵ Reported gonorrhea infection rates in Louisiana rose in 2000 with 314 cases per 100,000 people; however, then Louisiana experienced a decrease in 2001 dropping to 291 cases per 100,000 and decreased again to 246 per 100,000 in 2006.¹⁰ Infections from *N. gonorrhoeae* ordinarily occur in the urogenital tract. In females, recognizable symptoms customarily do not present before complications such as pelvic inflammatory disease (PID) arise; however, patients may present with odorless vaginal discharge, vaginal bleeding, and/or painful sexual intercourse. Males are commonly more symptomatic than females, presenting with purulent penile discharge and dysuria.^{2,11} PID may be a result of an ascending infection occurring after *N. gonorrhoeae* is present in the endocervix. Complications of PID include both infertility and ectopic pregnancy.^{2,9} Treatment regimens for uncomplicated gonococcal infections of the cervix, urethra, and rectum include 125 mg of ceftriaxone intramuscularly or 400 mg of cefixime by mouth both as one single dose. In the summer of 2002, the manufacturer of cefixime stopped producing cefixime tablets which eliminated an available oral cephalosporin to treat gonococcal infections; however, these tablets recently became available, providing an oral cephalosporin option.¹² Up until April 2007, the fluoroquinolones ciprofloxacin, ofloxacin, and levofloxacin were also available treatment options, but because of increasing fluoroquinolone resistance in the US these agents are no longer recommended by the CDC.¹³ Even though the latest CDC guidelines recommend spectinomycin as an alternative treatment for gonococcal infections, it has not been available in the US since May 2006.¹⁴ Even though limited evidence exists regarding their efficacy, other possible oral cephalosporin treatments for uncomplicated infections of the cervix, urethra, and rectum include 400 mg of cefpodoxime or 1 gram of cefuroxime axetil by mouth as a single dose.¹³ In patients with a documented severe allergic reaction to either penicillins or cephalosporins, 2 grams of azithromycin by mouth as a single dose may be used; however, this should not be used in the general population because of emerging resistance concerns.¹³ In a study published in 2003, twenty percent of men and forty-two percent of women diagnosed with gonorrhea were also infected with *Chlamydia trachomatis*.¹⁶ Due to the high probability of *C. trachomatis* coinfection, patients diagnosed with a gonococcal infection should also be treated for chlamydia.²

Chlamydia trachomatis is the most commonly reported infectious disease in the United States.² National infection rates of chlamydia were reported to be 348 per 100,000 in 2006; however, the rate for the same time period was 420 cases per 100,000 in the state of Louisiana.¹⁵ Infections with chlamydia and gonorrhea share some similarities. Like with gonorrhea, the most common site of chlamydial infection is the urogenital tract. Asymptomatic chlamydial infections are common in both males and females. Although in males symptoms including penile discharge resulting from urethritis and epididymitis cause them to search for treatment, it is generally after the disease has had the ability to be transmitted to others.^{2, 16}

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Also similar to gonococcal infections, complications in females with chlamydia include PID, infertility, and ectopic pregnancy.² Recommended treatment regimens include 1 gram of azithromycin by mouth as a single dose or 100 mg of doxycycline by mouth twice daily for seven days. An alternative treatment regimen is 500 mg of erythromycin base or 800 mg of erythromycin ethylsuccinate by mouth four times daily for seven days. These erythromycin alternatives may be less effective than azithromycin or doxycycline because of gastrointestinal side effects which often prohibits patients from being compliant with the regimen. Erythromycin also has many drug interactions including those which could lead to QTc prolongation. A second alternative is 300 mg of ofloxacin by mouth twice daily or 500 mg of levofloxacin once daily for seven days even though neither regimen is more cost effective nor provides an enhanced dosing regimen. In pregnant women with chlamydia, 1 gram of azithromycin by mouth as a single dose or 500 mg of amoxicillin three times daily for seven days are the treatments of choice due to the contraindication with doxycycline and fluoroquinolones in pregnancy and the gastrointestinal side effects associated with erythromycin.²

STDs are a concern in Louisiana and when left untreated may lead to negative consequences for both patients and their sexual partners. It is important to treat patients according to the CDC guidelines in order to decrease the likelihood that these negative consequences will occur as well as to decrease reinfection rates in patients and their partners. Patients diagnosed with any of these infections should be counseled on the importance of treatment and on methods to decrease the possibility of transmission to others.

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Antibiotic Treatments for Syphilis, Gonorrhea and Chlamydia for non-HIV infected Adults ^{2,13}

<i>STI</i>	<i>Recommended Treatment</i>	<i>Alternative Treatment</i>	<i>Recommended Treatment in Pregnancy</i>
Primary or Secondary Syphilis	benzathine penicillin G 2.4 million units IM in a single dose	doxycycline 100 mg by mouth twice daily for 14 days or tetracycline 500 mg by mouth four times daily for 14 days	benzathine penicillin G 2.4 million units IM in a single dose **desensitization and treatment with penicillin is recommended in pregnant patients with penicillin allergy
Tertiary Syphilis	benzathine penicillin G 2.4 million units IM once weekly for three weeks	doxycycline 100 mg by mouth twice daily for four weeks or tetracycline 500 mg by mouth four times daily for four weeks	benzathine penicillin G 2.4 million units IM once weekly for three weeks **desensitization and treatment with penicillin is recommended in pregnant patients with penicillin allergy
Uncomplicated gonococcal infections of cervix, urethra, rectum	ceftriaxone 125 mg IM in a single dose or cefixime 400 mg by mouth in a single dose Plus Chlamydia treatment if not ruled out	cefepodoxime 400 mg or cefuroxime axetil 1 gram by mouth as a single dose or azithromycin 2 grams by mouth in a single dose	ceftriaxone 125 mg IM in a single dose or cefixime 400 mg by mouth in a single dose
Chlamydia	azithromycin 1 g orally in a single dose or doxycycline 100 mg orally twice a day for 7 days	erythromycin base 500 mg orally four times a day for 7 days or erythromycin ethylsuccinate 800 mg orally four times a day for 7 days or ofloxacin 300 mg orally twice a day for 7 days or levofloxacin 500 mg orally once daily for 7 days	azithromycin 1 g orally in a single dose or amoxicillin 500 mg orally three times a day for 7 days



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