Louisiana Medicaid

Provider Update

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DHH Receives Federal Approval for LaCHIP Expansion

On February 27, 2008, the Department of Health and Hospitals (DHH) received approval from the Centers for Medicare and Medicaid Services (CMS), the Medicaid governing authority, to expand coverage under Louisiana Children's Health Insurance Program (LaCHIP) to uninsured children in working families with earnings up to 250 percent of the Federal Poverty Level (FPL). Enrollment for the expanded program, which will include a modest premium and co-payments, is slated to begin in May 2008.

In its present form, LaCHIP covers children younger than age 19 in families with earnings up to 200 percent of FPL or about $3,442 per month for a family of four. The expansion will allow a family of four earning $4,417 (based on 2008-2009 FPL figures) the opportunity to acquire public health care for their uninsured children.

The push to expand LaCHIP income limits began during the 2007 Regular Session of the Louisiana Legislature when both the House and Senate voted unanimously to expand coverage to families up to 300 percent of the Federal Poverty Level. On August 17, 2007, CMS issued a directive which resulted in Louisiana limiting the LaCHIP expansion to 250 percent of the FPL.

DHH is in the process of establishing procedures for the expansion, but the benefit package will be modeled after the state's employee benefit plan. Through the office of Group Benefits, DHH will offer a wide range of services to the new LaCHIP population that will include physician visits, immunizations, prescriptions and some mental health benefits.

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The expansion will require families qualifying under the new plan to pay a $50 monthly premium for coverage as well as co-payments when they access services. The deductible will be waived.

To discourage families from dropping private or employer-sponsored insurance in favor of public coverage, applicants must be uninsured for 12 months prior to applications unless loss of insurance was involuntary.

For more information about LaCHIP and the program's expansion, you may visit www.lachip.org or call 1-877-2LaCHIP (252-2447).

Special Medicaid Benefits to Children

The following notice is sent out to all Medicaid recipients annually. It is being published here so that providers may be aware of the special services available to children with developmental disabilities.

The following services are available to children and youth with developmental disabilities. To request these services, call the Office for Citizens with Developmental Disabilities (OCDD)/district/authority in your area.

DEVELOPMENTAL DISABILITES MEDICAID WAIVER SERVICES

To sign up for "waiver programs" that offer Medicaid and additional services to eligible persons (including those persons whose income may be too high to qualify for other Medicaid eligibility categories), you may ask to be added to the Developmentally Disabled Request for Services Registry (RFSR). The New Opportunities Waiver (NOW) and the Children's Choice Waiver both provide services in the home, instead of in an institution, to persons who have developmental disabilities. Both waivers offer the following services: family support, center-based respite, environmental accessibility modifications, and specialized medical equipment and supplies. In addition, **NOW** covers services to help individuals live alone in the community or to assist with employment, and professional and nursing services beyond those that Medicaid usually covers. The **Children's Choice Waiver** also includes family training. Children remain eligible for the Children's Choice Waiver until their nineteenth birthday, at which time they will be transferred to an appropriate DD Waiver.

(If you are accessing services for a child 0-3 please contact EarlySteps at 1-866-327-5978.)

A support coordinator works with you to develop a comprehensive list of all needed services (such as medical care, therapies, personal care services, equipment, social services, and educational services) then assists you in obtaining them. If you are a Medicaid recipient under the age of 21 and it is medically necessary, you may be eligible to receive support coordination services immediately by calling SRI (toll free) at 1-800-364-7828.

The following benefits are available to all Medicaid eligible children and youth under the age of 21 who have a medical need. To access these services, call KIDMED (toll free) at 1-877-455-9955 (or tty 1-877-544-9544).

MENTAL HEALTH REHABILITATION SERVICES

Children and youth with mental illness may receive mental health rehabilitation services. These services include clinical and medication management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; behavior intervention plan development and service integration. All mental health rehabilitation services must be approved by the Office of Mental Health Prior Authorization Unit.

PSYCHOLOGICAL AND BEHAVIORAL SERVICES

Children and youth who require psychological and/or behavioral services may receive these services from a licensed psychologist. These services include necessary assessments and evaluations, individual therapy, and family therapy.

EPSDT/KIDMED EXAMS AND CHECKUPS

Medicaid recipients under the age of 21 are eligible for checkups ("EPSDT screenings"). These checkups include a health history or physical exam; immunizations; laboratory tests (including lead blood level assessment); vision and hearing checks; and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed. EPSDT screenings may help to find problems, which need other health treatment or additional services. Children under 21 are entitled to receive all medically necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. This includes a wide range of services not covered by Medicaid for recipients over the age of 21.

PERSONAL CARE SERVICES

Personal Care Services (PCS) are provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing, and personal hygiene. PCS does not include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters. The Medicaid Home Health program or Extended Home Health program covers those medical services. PCS must be ordered by a physician. The PCS provider must request approval for the service from Medicaid.

EXTENDED NURSING SERVICES

Children and youth may be eligible to receive skilled nursing services in the home. These services are provided by a home health agency. A physician must order this service. Once ordered by a physician, the home health agency must request approval for the service from Medicaid.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, AUDIOLOGY SERVICES, and PSYCHOLOGICAL EVALUATION AND TREATMENT

If a child or youth needs rehabilitation services such as physical, occupational, or speech therapy, audiology services, or psychological evaluation and treatment; these services can be provided at school, in an early intervention center, in an outpatient facility, in a rehabilitation center, at home, or in a combination of settings, depending on the child's needs. For Medicaid to cover these services at school (for ages 3 to 21), or early intervention centers and *EarlySteps* (ages 0 to 3), they must be part of the IEP or IFSP. For Medicaid to cover the services through an outpatient facility, rehabilitation center, or home health, they must be ordered by a physician and be prior-authorized by Medicaid.

For information on receiving these therapies, you may contact your school or early intervention center. *Earlysteps* can be contacted (toll free) at 1-866-327-5978. You may call KIDMED referral assistance at 1-877-455-9955 to locate other therapy providers.

MEDICAL EQUIPMENT AND SUPPLIES

Children and youth can obtain any medically necessary medical supplies, equipment and appliances needed to correct, or improve physical or mental conditions. Medical equipment and supplies must be ordered by a physician. Once ordered by a physician, the supplier of the equipment or supplies must request approval for them from Medicaid.

TRANSPORTATION

Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours in advance.

Children under age 21 are entitled to receive all medically necessary health care, diagnostic services, treatment, and other measures that Medicaid can cover. This includes many services that are not covered for adults.

If you need a service that is not listed above call the referral assistance coordinator at KIDMED (toll free) 1-877-455- 9955 (or TTY 1-877-544-9544).

If they cannot refer you to a provider of the service you need, you may call 1-888-758-2220 for assistance.

Services Available to Medicaid Eligible Children Under the Age of 21

If you are a Medicaid recipient under the age of 21, you may be eligible for the following services:

***Doctor's Visits**
***Hospital (inpatient and outpatient) Services**
***Lab and X-ray Tests**
***Family Planning**
***Home Health Care**
***Dental Care**
***Rehabilitation Services**
***Prescription Drugs**
***Medical Equipment, Appliances and Supplies (DME)**
***Support Coordination**
***Speech and Language Evaluations and Therapies**
***Occupational Therapy**
***Physical Therapy**
***Psychological Evaluations and Therapy**
***Psychological and Behavior Services**
***Podiatry Services**
***Optometrist Services**
***Hospice Services**
***Extended Skilled Nurse Services**
***Residential Institutional Care or Home and Community Based (Waiver) Services**
***Medical, Dental, Vision and Hearing Screenings, both Periodic and Interperiodic**
***Immunizations**
***Eyeglasses**
***Hearing Aids**
***Psychiatric Hospital Care**
***Personal Care Services**
***Audiological Services**
***Necessary Transportation: Ambulance Transportation, Non-ambulance Transportation**
***Appointment Scheduling Assistance**
***Substance Abuse Clinic Services**
***Chiropractic Services**
***Prenatal Care**
***Certified Nurse Midwives**
***Certified Nurse Practitioners**
***Mental Health Rehabilitation**
***Mental Health Clinic Services**

and any other medically necessary health care, diagnostic services, treatment, and other measures which are coverable by Medicaid, which includes a wide range of services not covered for recipients over the age of 21.

If you need a service that is not listed above, you may call the referral assistance coordinator at KIDMED (toll free) 1-877-455-9955 (or TTY 1-877-544-9544). If they cannot refer you to a provider of the service you need call 225-342-5774.

If you are a Medicaid recipient, under age 21, and are on the DD Request for Services Registry, you may be eligible for support coordination services. To access these services, you must contact your Regional Office for Citizens with Developmental Disabilities. If you are a Medicaid recipient under age 21 and it is medically necessary, you may be able to receive support coordination services immediately by calling SRI (toll free) at 1-800-364-7828.

You may access other services by calling KIDMED (toll-free) at 1-877-455-9955. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

Some of these services must be approved by Medicaid in advance. Your medical provider should be aware of which services must be pre-approved and can assist you in obtaining those services. Also, KIDMED can assist you or your medical provider with information as to which services must be pre-approved.

Whenever health treatment or additional services are needed, you may obtain an appointment for a screening visit by contacting KIDMED. Such screening visits also can be recommended by any health, developmental, or educational professional. To schedule a screening visit, contact KIDMED (toll-free) at 1-800-259-4444 (or 928-9683, if you live in the Baton Rouge area), or by contacting your physician if you already have a KIDMED provider. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

Louisiana Medicaid encourages you to contact the KIDMED office and obtain a KIDMED provider so that you may be better served.

If you are a CommunityCARE recipient, please contact your primary care physician for assistance in obtaining any of these services or contact KIDMED at (toll-free) 1-877-455-9955.

CMS Proposes New Rules for Redesigning Medicaid

The following is a press release issued February 21, 2008, by the Centers for Medicare and Medicaid Services.

Two new proposed rules would give states unprecedented flexibility in designing their own Medicaid programs, including adjusting their benefit package to more closely align with beneficiary needs and requiring increased cost sharing by enrollees.

The proposed rules would implement provisions of the Deficit Reduction Act of 2005 and the Tax Relief and Health Care Act of 2006. The rules are the latest in a series of regulations to implement the Administration's goals of aligning Medicaid more closely with private market insurance and giving states more control over their Medicaid benefits packages.

"These new rules recognize that states are in the best position to design plans that provide Medicaid beneficiaries better health care for the same or even lower cost," Health and Human Services Secretary Mike Leavitt said. "The proposed rules will result in patients having more choices and greater control over their health care decisions."

The flexibility these proposals provide is valuable for the beneficiary and the state. States will now have the opportunity to offer beneficiaries health care that has the same value as plans that are being offered to other populations in the state, through alternative benefit packages called "benchmark plans."

Benchmark plans are models that states can use in designing new programs. These benchmark plans are similar to the flexibility provided to states under the State Children's Health Insurance Program (SCHIP). Benchmark coverage includes:

- The standard Blue Cross/Blue Shield preferred provider option service benefit plan under the Federal Employees Health Benefit Plan;
- State employee coverage;
- Coverage that is offered by the largest commercial health maintenance organization in the state; or
- Coverage that the Secretary of Health and Human Services approves.

These benchmark options provide states with the opportunity to target benefits to meet the specific needs of individuals. In some cases, state employee benchmark coverage may be more generous than the state Medicaid plan. Approved coverage may offer the opportunity for disabled individuals to obtain integrated coverage for acute care and community-based long-term care. For individuals who cannot afford the premiums associated with health insurance offered through their employer, states have the option of paying part of the employee premium to make it more affordable, so the employee can maintain private coverage.

States would also be able to create new benefit packages tailored to different populations. These proposed rules also give states the flexibility to provide wrap-around and additional benefits, such as dental coverage. This will provide increased efficiency in state programs by providing services in a more cost-effective manner while giving beneficiaries more comprehensive care."Until passage of the DRA, states had few options, other than through waivers, to update the health benefit packages offered through their Medicaid programs to meet the needs of the people they serve," CMS Acting Administrator Kerry Weems said. "These proposed changes allow states to use modern methods of providing health insurance coverage and encourage families to participate in their own health care decisions."

CMS also released proposed regulations on DRA provisions that allow states to change current premiums and cost sharing structures. These new provisions are similar to what is allowed under SCHIP and will not change existing cost sharing rules for Medicaid beneficiaries with family income below 100 percent of the federal poverty level (FPL). Individuals with family incomes between 100 and 150 percent of the FPL may see some cost sharing while monthly premiums can be charged to individuals with incomes above 150 percent of the FPL. As in SCHIP, all cost sharing must be limited to no more than five percent of the family's income. The 2008 FPL for a family of four is $21,200.

The proposed rules were published in the February 22, 2008 issue of the *Federal Register*.

A copy of the State Flexibility in Benefit Packages NPRM is available on the CMS website at:
http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2232P.pdf

A copy of the Premiums and Cost Sharing NPRM is available on the CMS website at:
http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2244P.pdf

NPI Compliance Reminder

The implementation date, May 23, 2008, for the use of the National Provider Identifier (NPI) is quickly approaching. Medicaid providers (excluding atypical providers, e.g. transportation, Environmental Accessibility Adaptation providers) who have not registered their NPI(s) with LA Medicaid will not be paid on or after May 23, 2008. If you have not registered your NPI(s), you may register online at www.lamedicaid.com in the secured provider area or call 225-216-6400 for assistance. For additional instructions regarding applying for and registering your NPI, you may go to the lamedicaid website.

NOTE: This implementation may require system changes to your billing software; so we request that you immediately contact your billing vendor or agent to be sure that your system reflects the necessary changes to add an NPI. These changes should be tested in order to prevent delays in your Medicaid payment.

Continue to visit the La Medicaid website, monitor RA messages and read the Provider Update to stay informed regarding the NPI implementation.

CDC State Preparedness Report Highlights Progress and Challenges

The following is a press release issued February 20, 2008, by the Centers for Disease Control and Prevention.

An inaugural report on public health preparedness released by the Centers for Disease Control and Prevention (CDC) indicates states have made significant progress with respect to emergency preparedness, but that significant challenges remain.

"This assessment of public health emergency preparedness is a major step forward," said Dr. Julie Gerberding, CDC director. "It illustrates the many specific ways that the investments we've been making since 2001 have increased states' capacity to quickly and effectively respond to a wide range of health hazards and emergencies. Today, for example, all states have emergency response plans, improved ability to identify and confirm public health threats, and more consistent and effective collaboration and communication between the many entities involved in responding to public health threats and emergencies."

More than $5 billion of federal funding has been distributed to the nation by CDC to improve public health preparedness and response since 2002.

"As a nation, we are better prepared today to respond to public health threats but the reality is that these efforts must be ongoing," said Richard Besser, M.D., director of CDC's Coordinating Office for Terrorism Preparedness and Emergency Response.

The CDC report, *Public Health Preparedness: Mobilizing State by State*, presents data that illustrate the progress state health departments have made in disease detection and investigation; laboratory testing capabilities; and planning, exercising and responding to public health emergencies. Key improvements from the report include:

- **Disease detection and investigation**. All state public health departments can now receive urgent reports about disease 24 hours a day, seven days a week. In 1999, only 12 states could do so. In addition, all states share information using the Epidemic Information Exchange (Epi-X), a secure, CDC-based communications system that helps track disease outbreaks. The number of users of this network nationwide has increased from 1,366 in 2001, to 4,646 in 2006.
- **Public health laboratories**. The number of laboratories that can test and analyze samples has nearly doubled since 2001.
- **Response plans**. All states have developed detailed emergency response plans to address all hazards, including an influenza pandemic. All states also now have plans to distribute the Strategic National Stockpile's federal caches of pharmaceuticals, antidotes, and medical supplies used for an emergency.
- **Training**. All public health departments now systematically and routinely train their workers in a wide range of crucial emergency response areas.

According to Besser, CDC's preparedness report is an important part of the agency's focus on measuring and documenting results, systematically using data to continuously improve programs and increasing accountability regarding the country's investment in preparedness activities.

"We recognize that CDC's report presents important data on some preparedness activities but does not provide information on all areas of preparedness," said Dr. Besser. "The nation's public health preparedness information and measures need to improve and CDC continues to engage with states and others to identify and incorporate effective public health emergency preparedness systems that enhance the nation's ability to respond."

CDC's approach has been to support public health preparedness for all hazards, including natural, biological, chemical, radiological, and nuclear events. This work falls under one of the agency's overarching health protection goals: "People prepared for emerging health threats - people in all communities will be protected from infectious, occupational, environmental, and terrorist threats."

CDC's report also provides a better understanding of where the major national and state challenges lie, and the areas where more progress needs to be made. Preparedness challenges include:

- Improving the ability to quickly dispense medicines and vaccines in an affected community
- Increasing the use of electronic health data for preparedness and response by networking surveillance systems
- Improving legal preparedness by helping states and other jurisdictions implement public health mutual aid agreements, which enable sharing of supplies, equipment, personnel, and information during emer gencies
- Exercising public health systems to continuously improve capability and demonstrate readiness

CDC released the report during the annual Public Health Preparedness Summit in Atlanta today. The summit is coordinated by the National Association of City and County Health Officials. The report and state specific information is available on CDC's Web site at http://emergency.cdc.gov/publications/feb08phprep.

Pursuing Third Party Liability Payments

The Department of Health and Hospitals, Bureau of Health Services Financing promulgated a Rule in the April 20, 2008 issue of the *Louisiana Register* (Volume 34, Number. 4) regarding provider billing and recovery from liable third parties in traumatic injuries or accident cases. The Rule further clarifies provider responsibilities in pursuing a liable third party for payment in excess of the amount paid by Medicaid.

A provider who pursues a liable or potentially liable third party for payment must:

- Establish his right to payment separate of any amounts claimed and established by the recipient, such as in compliance with Louisiana Revised Statute 9:4751 et seq.; or
- Obtain a settlement or award in his own name separate from a settlement or award obtained by, or on behalf of, the recipient; or
- Enter into a written agreement with the recipient, the recipient's legal representative, or recipient's attorney in fact that specifies the amount which will be paid to the provider separate from the settlement or award obtained by the recipient.

A written notification must be submitted to the Medicaid Third Party Recovery (TPR) Unit within 365 days of the occurrence of the incident or accident if the provider has accepted Medicaid payment and wishes to pursue the difference between the amount billed and amount paid by Medicaid (hereafter referred to as the "difference"). The notice shall contain identifying information regarding the recipient (i.e. name, date of birth, Social Security number or Medicaid identification number or both), the date of the accident or incident as well as any information regarding the existence or possible existence of a liable third party. The notice shall be sent to the following address:

The Department of Health and Hospitals
Bureau of Health Services Financing
Third Party Recovery Unit
453 Spanish Town Road
Baton Rouge, LA 70802
FAX: (225) 342-1376

Within 15 working days of receiving the difference, the provider must submit the Notification to Louisiana Medicaid form to the TPR Unit to determine whether Medicaid has received compensation from all service providers for all payments for health care services rendered to a recipient because of an accident or incident. A provider cannot disburse the difference until the TPR Unit notifies the provider that the Medicaid Program has received all applicable payments (i.e. Medicaid has been made "whole").

If the Bureau accepts less than full reimbursement, excluding any partial payment, Medicaid will be considered to have been made whole. Within 15 working days of receiving the Notification to Louisiana Medicaid Form, the TPR Unit will issue a notice to the provider indicating that Medicaid has been made whole.

If Medicaid has not been made whole, the provider has 15 working days from the date of the TPR Unit's notice to return the difference to the remitter and provide confirmation to the TPR Unit using the Notification to Louisana Medicaid form.

If a provider has knowledge that an individual is a Medicaid recipient and is receiving or has received health care services that may be covered by Medicaid because of the accident or incident, the provider is prohibited from:

- Demanding any payment from the Medicaid recipient or his representative; or
- Pursuing collection of any type against the Medicaid recipient or his representative.

There are no rules or regulations that would prevent a provider from demanding payment from, or pursuing any type of collection efforts for the difference against any liable or potentially liable third party, directly or through the Medicaid recipient or his representative who is demanding payment from any liable or potentially liable third party.

The Notification to Louisiana Medicaid Form can be found at lamedicaid.com under the forms link. The provisions of the Rule are not retroactive and will apply only to those claims for accidents/incidents occurring on or after the effective date of this Rule, which was April 20, 2008.

For additional information, contact Bill Perkins at the above address or at (225) 342-8662.

Professional Services Providers and EDI Vendors

Information Required on Claims for Physician-Administered Drugs

A new federal statute mandates that providers must begin reporting National Drug Code (NDC) information for all physician-administered drugs* on claim submissions. This requirement applies to both electronic and hard copy claims.

Effective for dates of service on or after March 1, 2008, physicians, physician groups, APRNs, and physician assistants are required to submit NDC information and the corresponding HCPCS code for physician-administered drugs on the 837P (Professional transaction) and the CMS-1500 claim form. Billing instructions for the CMS-1500 claim form are located on the LA Medicaid web site, www.lamedicaid.com, under the Training link - 2007 Training Packets. The LA Medicaid EDI Companion Guide for the 837P has been revised (2/2008) to include this information for EDI billing and the revision is available on the web site. The guide can be found under the link, HIPAA Billing Instructions and Companion Guides.

This means that any LA Medicaid covered service submitted with a HCPCS procedure code beginning with "J" for a physician-administered drug must be accompanied by the actual NDC code from the package of the drug administered and other required information. The information must be entered on the claim submission EXACTLY as indicated in the CMS-1500/837P instructions to prevent future claim denials. 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.

Providers, vendors, billing agents, and clearinghouses must immediately begin updating their billing systems to accommodate this mandate.

Effective for dates of service on or after March 1, 2008, new claims processing edits were implemented that will ultimately deny claims that do not contain the required, accurate NDC information submitted in accordance with the billing instructions. The following edits are in place for both the 837P and CMS-1500 claim form.

Edit 120 - "Quantity Invalid/Missing"
Edit 127 - "NDC Code Missing or Incorrect"
Edit 231 - "NDC Code Not on File"

To date, these edits are educational, and claims history indicates that many claims are being submitted with the required data entered incorrectly on the claim. Once these edits become denial edits in the near future, any claims with incorrectly entered data will deny. Please review the entry of this information and ensure that it is correct and complete.

With the implementation of this mandate, physician administered drug claims will be invoiced to drug manufacturers for Medicaid rebates. Louisiana Medicaid may need to audit or review these claims if requested by the drug manufacturers or if any outlier billings are detected. Each provider must retain all records for five (5) years from the date of service or until all audit questions, disputes, or review issues are concluded. At times, a drug manufacturer may question the invoice amount, which results in a drug rebate dispute. If this occurs, you may be contacted in order to request a copy of your office records, which includes documentation pertaining to the billed HCPCS/NDC code. Requested records may include drug/NDC invoices indicating the purchase of drugs and documentation showing what drug (name, strength, and amount) was administered to the Medicaid patient and on what date; verification/certification of the units billed on the claim(s); and copies of the labels from the drug packages.

NOTE 1: Rural Health Clinics, Federally Qualified Health Centers, and Mental Health Clinics are not included in the implementation of this mandate.

NOTE 2: Effective **on or before June 30, 2008**, providers will be required to submit NDC information and the corresponding HCPCS code on the 837I (Institutional transaction) and the UB-04 claim forms. Billing instructions for the UB-04 form and 837I transaction are forthcoming.

Providers must monitor RA messages and the web site closely for the most current information concerning this important change.

* Physician-administered drugs include any drugs ordered by a doctor (or APRN with prescriptive authority), regardless of which clinical professional actually administers the drug.

Professional Services

Presumptive Eligibility Determinations for Children Postponed

An article entitled "Medicaid Access for Children is Accelerated" appeared in the January-February 2008 issue of the Provider Update regarding the implementation of presumptive eligibility determinations for children for Medicaid and LaChip. The Department has determined that it is necessary to postpone the implementation of this policy change at this time.

Nursing Facility Providers

OAAS Issues Reminders on LOCET Registration

The Office of Aging and Adult Services (OAAS) wants to remind providers of the LOCET procedures.

All persons completing the Level of Care Eligibility Tool (LOCET) must be trained by the Department of Health and Hospitals (DHH), or a DHH trained LOCET Intake Analyst Trainer (IAT). If you were trained by DHH as a LOCET Intake Analyst Trainer, you are currently qualified to train others on how to complete a LOCET.

Once an individual has been trained in the proper interview and submission techniques for LOCET, he/she must complete and submit the LOCET Intake Analyst Registration form located on the Office of Aging and Adult Services (OAAS) website at: www.oaas.dhh.louisiana.gov. The completed registration form must be faxed to the number indicated on the form.

An Intake Analyst Registration Number will be issued for the newly trained individual and faxed to the number, which was provided on the registration form.

The intake analyst must have a LOCET Intake Analyst Number **prior to completing a LOCET** and use that specific number on each LOCET he/she completes. The OAAS Nursing Home Admissions unit will not process a LOCET which does not show a valid Intake Analyst Registration Number.

The intake analyst must only use his/her registration number on LOCETs that he/she completes. **An intake analyst's number must not be shared with other staff members, using someone else's number will be considered falsification of a legal document.**

Only the most current LOCET forms must be used. **Outdated forms will be rejected and will delay the processing of the admissions packet.**

Nursing Facility Providers (Cont.)

LOCET Manuals, Reference Guides, etc., LOCET forms and information are posted and updated regularly on the DHH/OAAS website at: www.oaas.dhh.louisiana.gov,click on right-hand tab - "Current LOCET forms and Information".

It is critical that your facility have well-trained and well-informed primary and back up intake analyst staff at all times. Receiving training directly from DHH staff is the optimal means for intake analysts to be trained. Training is scheduled on a recurring basis in Baton Rouge several times per year. Again, check the DHH/OAAS website at www.oaas.dhh.louisiana.gov for information regarding the next scheduled LOCET training session.

When an intake analyst leaves or transfers from a facility, a LOCET Intake Analyst Registration form must be submitted to OAAS. This form will notify OAAS that the particular intake analyst and IA Number are no longer associated with the original facility. In this case, you should check "No longer employed by this facility/agency" and list the last date of employment.

The intake analyst is responsible for submitting a LOCET Intake Analyst Registration Request form indicating a new place of employment to OAAS. In that case, the intake analyst should check "Registration Update" on the form with the new facility's information shown.

Questions or concerns regarding this process may be directed to Janet St. Angelo at jstangel@dhh.la.gov or Karen Dodson at kdodson@dhh.la.gov.

Home and Community Based Waiver Providers

Office of Aging and Adult Services Awarded Grant

The Department of Health and Hospitals, Office of Aging and Adult Services (OAAS) has been awarded a $285,000.00 Person-Center Planning (PCP) and Implementation Grant from the Centers for Medicare and Medicaid Services. The grant is entitled "Facilitating Opportunities for Choice and Utilization of Strengths" (FOCUS).

The goal of Louisiana's PCP Grant is twofold: (1) to implement an effective, strengths-based, person-centered planning model for older adults and persons with disabilities who use OAAS home and community-based services statewide, and (2) to develop and implement a Caregiver Needs Assessment (CNA) tool as part of the person-centered planning process. OAAS plans to incorporate the PCP model, the MDS-HC Assessment, and the CNA Tool into an electronic comprehensive plan of care (CPOC) with the goal of 100 percent participant-level implementation of person centered planning in all plans of care by the end of the grant.

The implementation of the CNA Tool will assist in identifying the strengths and needs of caregivers so participants are assured that the CPOCs effectively utilize caregivers' strengths while assisting in developing and/or retaining informal supports. OAAS plans to link the electronic CPOC to a resource directory sponsored in part by the Louisiana Aging and Disability Resource Center grant. Initial training at the regional level will be conducted by the grant project director and OAAS state office staff. A train-the-trainer model will be used to complete training of assessors and support coordinators at the local level. OAAS will measure outcomes of the grant using participant satisfaction and systems evaluations that audit the delivery of supports per an individual's person-centered plan.

RA Corner

Professional Services Providers

Selected Immunization Codes Have Been Made Payable

Immunization administration Current Procedural Terminology (CPT) codes 90465-90648, 90473, and 90474 have been made payable and added to the current claims processing system. Providers should refer to the CPT code description to determine the appropriate code for the administration of a vaccine. Updated information regarding the use of these codes can be found in the 2007 Provider Training materials for KIDMED and Professional Services.

Previously denied claims for these immunization administration codes will be systematically recycled from date of service January 1, 2006 forward. Providers will be notified by RA messages when this recycle of denied claims is complete.

Coding Critical Care Services Claims

Professional services providers submitting claims for Critical Care Services, (which include adult, pediatric, and neonatal critical care and intensive services) should refer to the Current Procedural Terminology (CPT) Manual for direction and the most current description of procedures and services included in the Critical Care Services codes. Current critical care code ranges that include services that should not be reported separately include 99291-99292, 99293-99300, and 99477.

If nationally approved changes occur to CPT codes at a future date that relate to critical care services, providers are to follow the most accurate coding available for the particular date of service, unless directed otherwise.

Payments to providers for services included in the critical care procedure codes as defined by CPT are subject to post payment review and recovery of overpayments.

Highlights of the Major Changes in the New Asthma Treatment Guidelines

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According to the current asthma guidelines published in 2007, more than 22 million Americans have asthma. It is one of the most common chronic diseases of childhood, affecting more than 6 million children. Some of the effects of asthma include burden to the patients, families, and society in terms of loss of work and school, lessened quality of life, and emergency department visits, hospitalizations, and death.

This review highlights some of the major changes in the most recent version of the NHLBI Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma as they relate to the previously issued guidelines. More information can be found in the full report available at http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm. This review focuses on changes made in many sections including: asthma control and severity, impairment and risk, patient education and control of environmental factors, stepwise approach management, and the treatment of asthma exacerbations.

Asthma Control and Severity

Asthma control is now recommended as the goal of asthma therapy. It is also important to distinguish between classifying asthma severity and monitoring asthma control. Asthma severity is defined as the intrinsic intensity of the disease process, and classification of the severity of asthma is needed for initiating therapy. Asthma control is the degree to which the manifestations of asthma are minimized by therapeutic interventions. Control should be assessed and monitored so that therapy can be adjusted accordingly.

Impairment and Risk

Another focus of the current guidelines is on impairment and risk as the two most important domains of severity and control. Impairment is defined by the guidelines as the frequency and intensity of symptoms and functional limitations the patient is experiencing, while risk is the likelihood of an asthma exacerbation, decline in lung function, or risk for adverse effect from medication. These two domains are different manifestations of asthma and could respond differently to treatment.

Patient Education and Control of Environmental Factors
Patient education is an important and fundamental aspect of asthma treatment, and should occur at every point of care including clinics, emergency departments, hospitals, pharmacies, schools, community settings, and the patient's home. Environmental control measures must include several approaches to reduce exposure because single interventions are not as effective. Also, subcutaneous immunotherapy should be considered for anyone with asthma defined as step 2-4, if there is a clear relationship between asthma symptoms and a particular allergen. Finally, any comorbid conditions that could worsen asthma should be optimally treated.

Stepwise Approach
The stepwise approach to the management of asthma has been increased from 4 to 6 steps of care. Although medications have been repositioned within the six steps, inhaled corticosteroids (ICS) continue as the preferred long-term control therapy for all ages. Due to the variable course of the disease and age-related medication effects, treatment recommendations are now presented for three age groups (0 - 4 years of age, 5-11 years of age, and 12 years of age and older).

Treatment of Asthma Exacerbations
The classification of an asthma exacerbation that requires emergency care is now defined as a forced expiratory volume in one second (FEV1) or peak expiratory flow (PEF) of <40 percent. Also, a FEV1 or PEF >70 percent is a goal for discharge from an emergency care department. The new guidelines encourage the development of prehospital asthma treatment protocols for emergency medical services. Finally, there are new recommendations for the medical treatment of asthma exacerbations which include:

- Addition of levalbuterol to the list of options for short acting beta 2 agonists
- Addition of magnesium sulfate or heliox for unresponsive patients
- Emphasis on the use of oral corticosteroids rather than doubling the ICS dose for home management
- Emphasis on the fact that anticholinergics are used in emergency care, not hospital care
- Consideration for initiation of ICS at discharge if patient is not currently on this treatment

This review addressed some of the major changes in the recently released Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma. For a quick reference summarizing the complete guidelines, refer to the following Figures 1-9.

FIGURE 1 - CLASSIFYING ASTHMA SEVERITY AND INITIATING TREATMENT IN CHILDREN 0 - 4 YEARS OF AGE

Assessing severity and initiating therapy in children who are not currently taking long-term control medication

Components of Severity		Classification of Asthma Severity (0 - 4 years of age)			
		Intermittent	Persistent		
			Mild	Moderate	Severe
Impairment	Symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	0	1 -2x/month	3 - 4x/month	>1x/week
	Short-acting $beta_2$-agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not daily	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
Risk	Exacerbations requiring oral systemic corticosteroids	0 - 1/year	≥2 exacerbations in 6 months requiring oral systemic corticosteroids, or ≥4 wheezing episodes/ 1 year lasting >1 day AND risk factors for persistent asthma		
		<=Consider severity and interval since last exacerbation. => Frequency and severity may fluctuate over time. Exacerbations of any severity may occur in patients in any severity category.			
Recommended Step for Initiating Therapy (See Figure 4 for treatment steps.)		Step 1	Step 2	Step 3 and consider short course of oral systemic corticosteroids	
		In 2 - 6 weeks, depending on severity, evaluate level of asthma control that is achieved. If no clear benefit is observed in 4 - 6 weeks, consider adjusting therapy or alternative diagnoses.			

Key: EIB, exercise-induced bronchospasm

Notes

- The stepwise approach is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.
- Level of severity is determined by both impairment and risk. Assess impairment domain by patient's/caregiver's recall of previous 2-4 weeks. Symptom assessment for longer periods should reflect a global assessment such as inquiring whether the patient's asthma is better or worse since the last visit. Assign severity to the most severe category in which any feature occurs.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma severity. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past 6 months, or ≥4 wheezing episodes in the past year, and who have risk factors for persistent asthma may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

Reference:

Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma - Summary Report 2007
http://www.nhlbi.nih.gov/guidelines/asthma

FIGURE 2 - CLASSIFYING ASTHMA SEVERITY AND INITIATING TREATMENT IN CHILDREN 5 - 11 YEARS OF AGE

Assessing severity and initiating therapy in children who are not currently taking long-term control medication

Components of Severity		Classification of Asthma Severity (5 - 11 years of age)			
		Intermittent	Persistent		
			Mild	Moderate	Severe
Impairment	Symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	≤2x/month	3 - 4x/month	>1x/week but not nightly	Often 7x/week
	Short-acting $beta_2$-agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not daily	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
	Lung function	- Normal FEV1 between exacerbations -FEV1 >80% predicted - FEV1/FVC >85%	- FEV1 = >80% predicted - FEV1/FVC >80%	- FEV1 = 60-80% predicted - FEV1/FVC =75-80%	- FEV1 <60% predicted - FEV1/FVC <75%
Risk	Exacerbations requiring oral systemic corticosteroids	0 - 1/year (see note)	≥2/year (see note) ==>		
		<=Consider severity and interval since last exacerbation. => Frequency and severity may fluctuate over time for patients in any severity category. Relative annual risk of exacerbations may be related to FEV1.			
Recommended Step for Initiating Therapy (See Figure 5 for treatment steps.)		Step 1	Step 2	Step 3, medium-dose ICS option	Step 3, medium-dose ICS option, or Step 4
				and consider short course of oral systemic corticosteroids	
		In 2-6 weeks, evaluate level of asthma control that is achieved and adjust therapy accordingly.			

Key: EIB, exercise-induced bronchospasm; FEV1, forced expiratory volume in 1 second; FVC, forced vital capacity; ICS, inhaled corticosteroids

Notes

- The stepwise approach is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.
- Level of severity is determined by both impairment and risk. Assess impairment domain by patient's/caregiver's recall of previous 2-4 weeks and spirometry. Assign severity to the most severe category in which any feature occurs.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma severity. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate greater underlying disease severity. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

Reference:

Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma - Summary Report 2007
http://www.nhlbi.nih.gov/guidelines/asthma

FIGURE 3 - CLASSIFYING ASTHMA SEVERITY AND INITIATING TREATMENT IN YOUTHS ≥12 YEARS OF AGE AND ADULTS

Assessing severity and initiating therapy in children who are not currently taking long-term control medication

Components of Severity		Classification of Asthma Severity ≥12 years of age			
		Intermittent	Persistent		
			Mild	Moderate	Severe
Impairment Normal FEV1/FVC: 8-19 yr 85% 20-39 yr 80% 40-59 yr 75% 60-80 yr 70%	Symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	≤2x/month	3 - 4x/month	>1x/week but not nightly	Often 7x/week
	Short-acting $beta_2$-agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not daily, and not more than 1x on any day	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
	Lung function	- Normal FEV1 between exacerbations -FEV1 >80% predicted -FEV1/FVC normal	-FEV1 >80%predicted -FEV1/FVC normal	-FEV1 >60% but <80% predicted -FEV1/FVC reduced 5%	-FEV1 <60% predicted -FEV1/FVC reduced>5%
Risk	Exacerbations requiring oral systemic corticosteroids	0 - 1/year (see note)	≥2/year (see note) ==>		
		<=Consider severity and interval since last exacerbation. => Frequency and severity may fluctuate over time for patients in any severity category. Relative annual risk of exacerbations may be related to FEV1.			
Recommended Step for Initiating Therapy (See Figure 6 for treatment steps.)		Step 1	Step 2	Step 3 and consider short course of oral systemic corticosteroids	Step 4 or 5
		In 2 - 6 weeks, evaluate level of asthma control that is achieved and adjust therapy accordingly.			

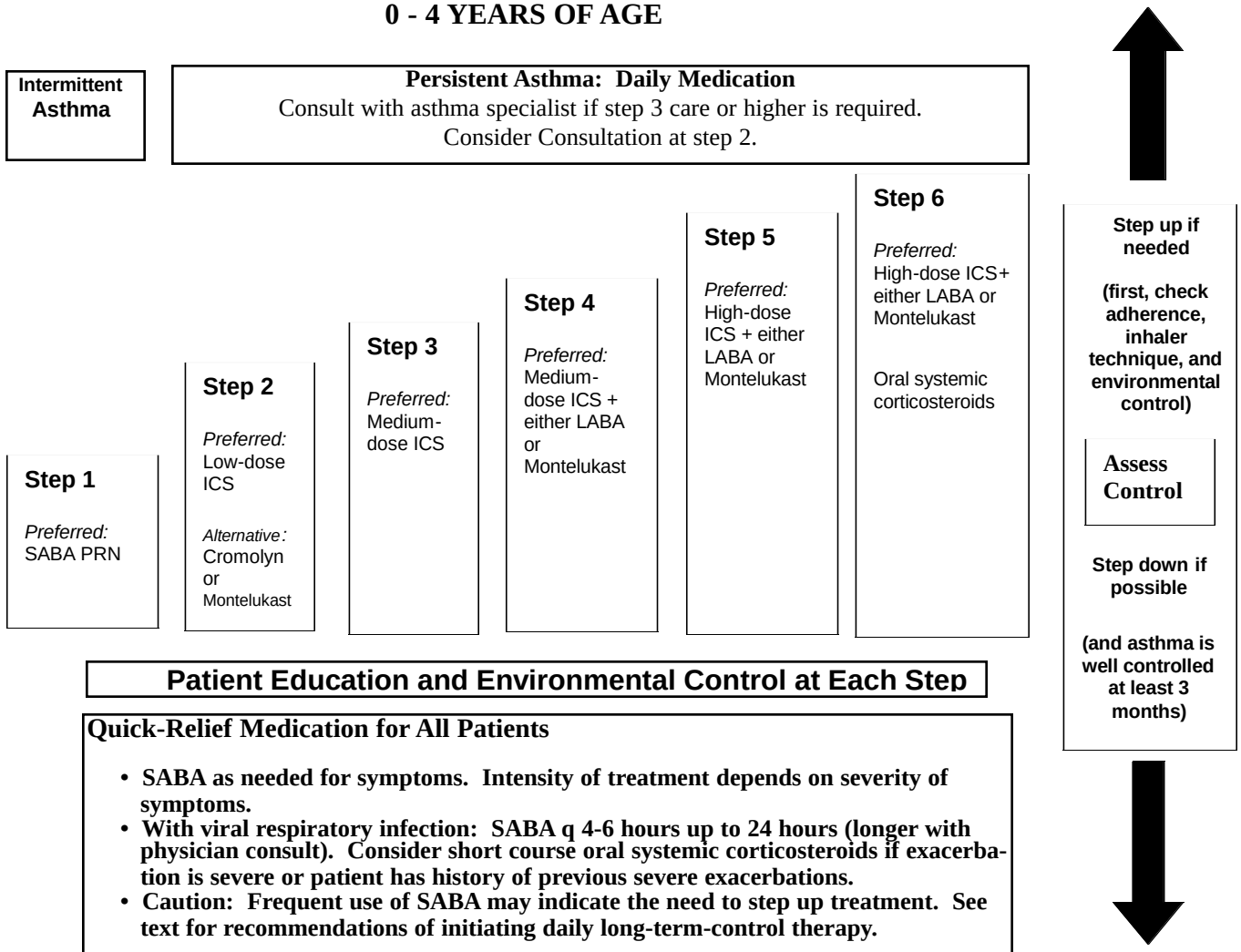
Key: FEV1, forced expiratory volume in 1 second; FVC, forced vital capacity; ICU, intensive care unit

Notes

- The stepwise approach is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.
- Level of severity is determined by assessment of both impairment and risk. Assess impairment domain by patient's/caregiver's recall of previous 2 - 4 weeks and spirometry. Assign severity to the most severe category in which any feature occurs.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma severity. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate greater underlying disease severity. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

Reference:
Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma - Summary Report 2007
http://www.nhlbi.nih.gov/guidelines/asthma

FIGURE 4 - STEPWISE APPROACH FOR MANAGING ASTHMA IN CHILDREN 0 - 4 YEARS OF AGE



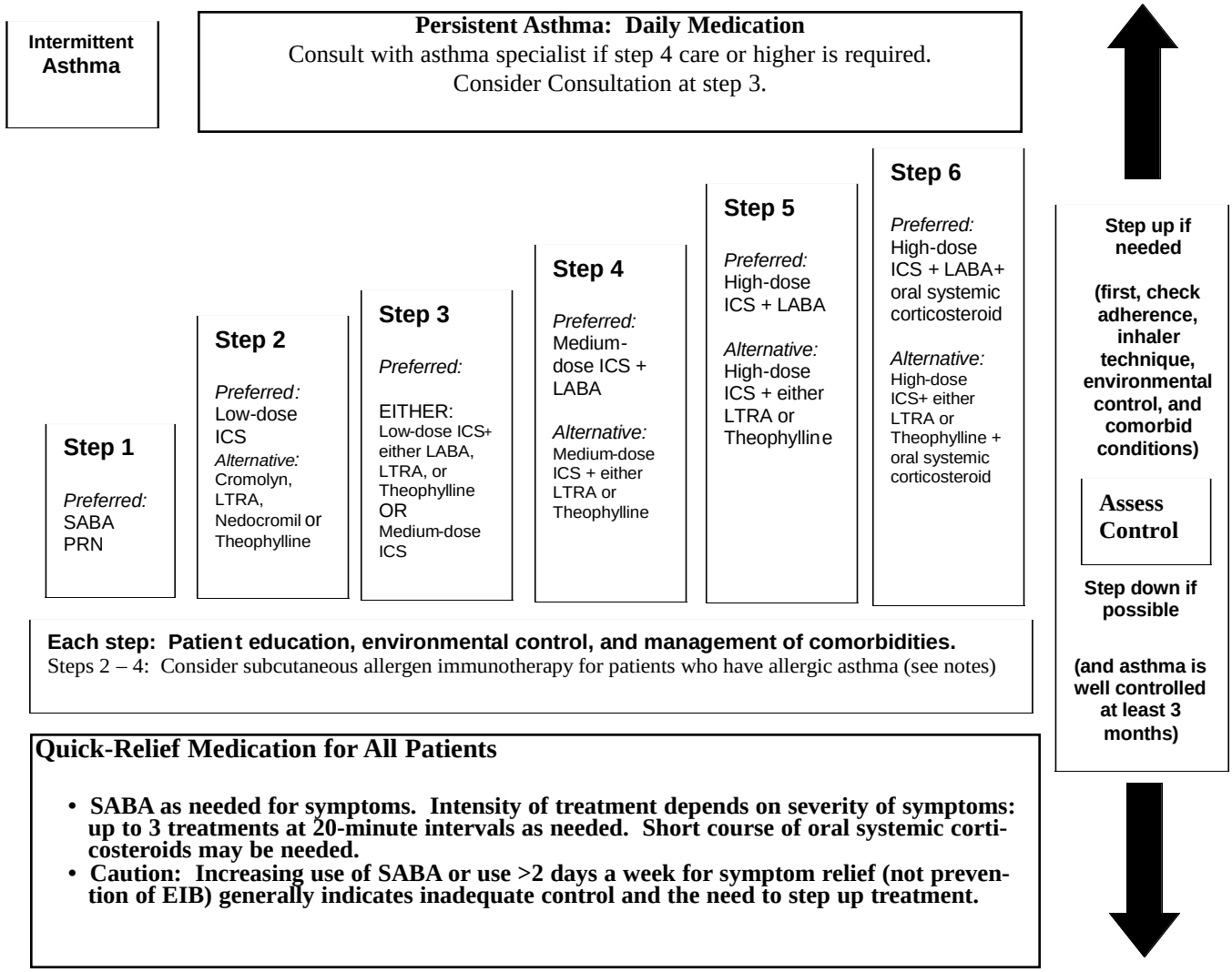
Key: **Alphabetical order is used when more than one treatment option is listed within either preferred or alternative therapy.** ICS, inhaled corticosteroid; LABA, inhaled long-acting beta2-agonist; SABA, inhaled short-acting beta2-agonist

Notes:

- The stepwise approach is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.
- If alternative treatment is used and response is inadequate, discontinue it and use the preferred treatment before stepping up.
- If clear benefit is not observed within 4 - 6 weeks and patient/family medication technique and adherence are satisfactory, consider adjusting therapy or alternative diagnosis.
- Studies on children 0 - 4 years of age are limited. Step 2 preferred therapy is based on Evidence A. All other recommendations are based on expert opinion and extrapolation from studies in older children.

Reference:
Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma - Summary Report 2007
http://www.nhlbi.nih.gov/guidelines/asthma

FIGURE 5 - STEPWISE APPROACH FOR MANAGING ASTHMA IN CHILDREN 5 - 11 YEARS OF AGE



Key: **Alphabetical order is used when more than one treatment option is listed within either preferred or alternative therapy.** ICS, inhaled corticosteroid; LABA, inhaled long-acting beta2-agonist; LTRA, leukotriene receptor antagonist; SABA, inhaled short-acting beta2-agonist

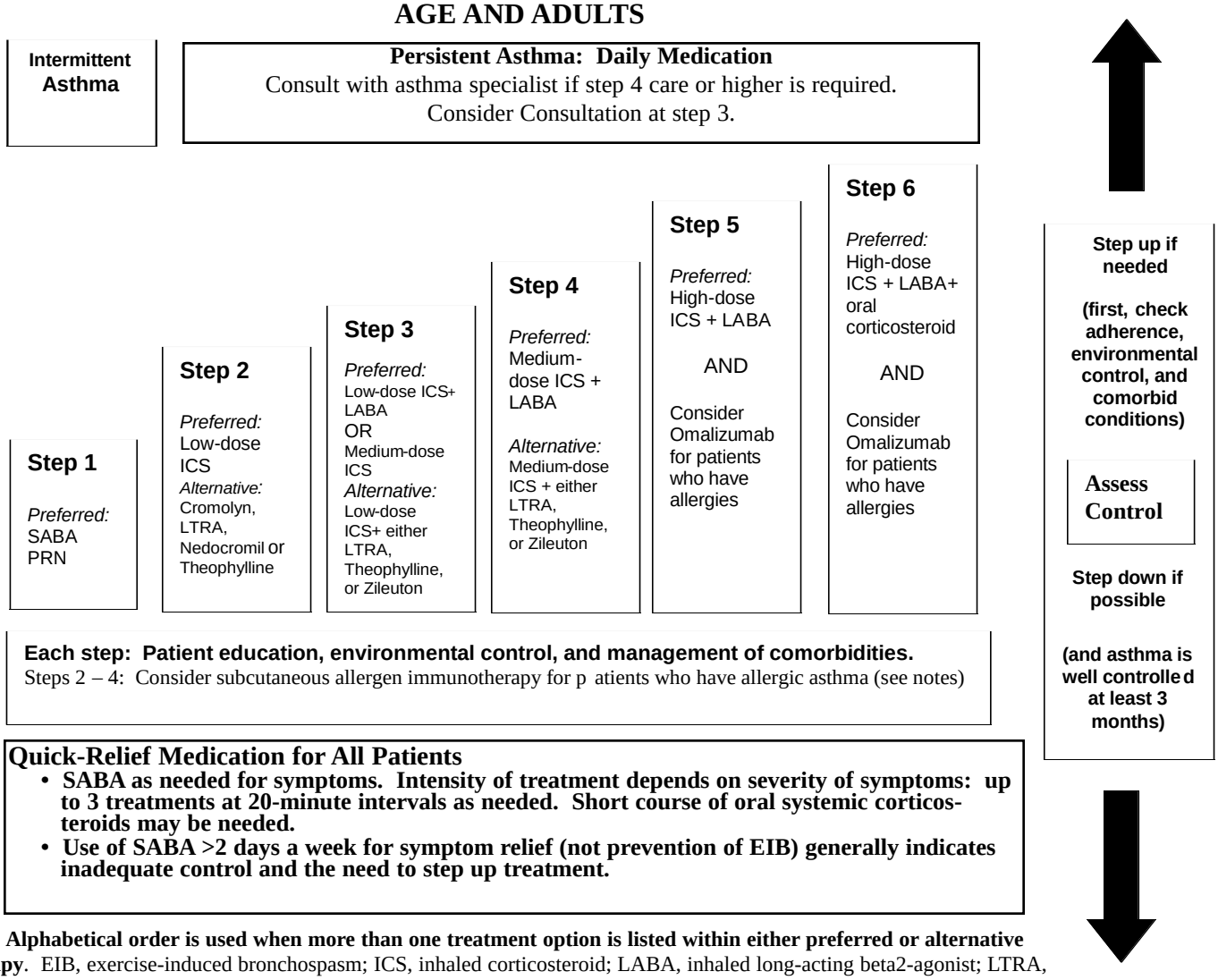
Notes:

- The stepwise approach is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.
- If alternative treatment is used and response is inadequate, discontinue it and use the preferred treatment before stepping up.
- Theophylline is a less desirable alternative due to the need to monitor serum concentration levels.
- Step 1 and step 2 medications are based on Evidence A. Step 3 ICS + adjunctive therapy and ICS are based on Evidence B for efficacy of each treatment and extrapolation from comparator trials in older children and adults - comparator trials are not available for this age group; steps 4-6 are based on expert opinion and extrapolation from studies in older children and adults.
- Immunotherapy for steps 2-4 is based on Evidence B for house-dust mites, animal danders, and pollens; evidence is weak or lacking for molds and cockroaches. Evidence is strongest for immunotherapy with single allergens. The role of allergy in asthma is greater in children than in adults. Clinicians who administer immunotherapy should be prepared and equipped to identify and treat anaphylaxis that may occur.

Reference:

Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma - Summary Report 2007
http://www.nhlbi.nih.gov/guidelines/asthma

FIGURE 6 - STEPWISE APPROACH FOR MANAGING ASTHMA IN YOUTHS ≥ 12 YEARS OF AGE AND ADULTS



Key: **Alphabetical order is used when more than one treatment option is listed within either preferred or alternative therapy**. EIB, exercise-induced bronchospasm; ICS, inhaled corticosteroid; LABA, inhaled long-acting beta2-agonist; LTRA, leukotriene receptor antagonist; SABA, inhaled short-acting beta2-agonist

Notes:

- The stepwise approach is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.
- If alternative treatment is used and response is inadequate, discontinue it and use the preferred treatment before stepping up.
- Zileuton is a less desirable alternative due to limited studies as adjunctive therapy and the need to monitor liver function. Theophylline requires monitoring of serum concentration levels.
- In step 6, before oral systemic corticosteroids are introduced, a trial of high-dose ICS + LABA + either LTRA, theophylline, or zileuton may be considered, although this approach has not been studied in clinical trials.
- Step 1, 2, and 3 preferred therapies are based on Evidence A; step 3 alternative therapy is based on Evidence A for LTRA, Evidence B for theophylline, and Evidence D for zileuton. Step 4 preferred therapy is based on Evidence B, and alternative therapy is based on Evidence B for LTRA and theophylline, and Evidence D for zileuton. Step 5 preferred therapy is based on Evidence B. Step 6 preferred therapy is based on (EPR - 2 1997) and Evidence B for omalizumab.
- Immunotherapy for steps 2 - 4 is based on Evidence B for house-dust mites, animal danders, and pollens; evidence is weak or lacking for molds and cockroaches. Evidence is strongest for immunotherapy with single allergens. The role of allergy in asthma is greater in children than in adults.
- Clinicians who administer immunotherapy or omalizumab should be prepared and equipped to identify and treat anaphylaxis that may occur.

Reference:

Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma - Summary Report 2007
http://www.nhlbi.nih.gov/guidelines/asthma

FIGURE 7 - ASSESSING ASTHMA CONTROL AND ADJUSTING THERAPY IN CHILDREN 0 - 4 YEARS OF AGE

Components of Control		Classification of Asthma Control (0 - 4 years of age)		
		Well Controlled	**Not Well Controlled**	**Very Poorly Controlled**
Impairment	Symptoms	≤2 days/week	>2 days/week	Throughout the day
	Nighttime awakenings	≤1x/month	>1x/month	>1x/week
	Interference with activity	None	Some limitation	Extremely limited
	Short-acting $beta_2$-agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
Risk	Exacerbations requiring oral systemic corticosteroids	0 - 1/year	2 - 3/year	>3/year
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		
Recommended Action for Treatment **(See Figure 4 for treatment steps.)**		- Maintain current treatment. - Regular followup every 1 - 6 months. - Consider step down if well controlled for at least 3 months.	- Step up (1 step) and - Reevaluate in 2 - 6 weeks - If no clear benefit in 4 - 6 weeks, consider alternative diagnoses or adjusting therapy. - For side effects, consider alternative treatment options.	- Consider short course of oral systemic corticosteroids, - Step up (1 -2 steps), and - Reevaluate in 2 weeks. - If no clear benefit in 4 -6 weeks, consider alternative diagnosis or adjusting therapy. - For side effects, consider alternative treatment options.

Key: EIB, exercise-induced bronchospasm

Notes

- The stepwise approach is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.
- The level of control is based on the most severe impairment or risk category. Assess impairment domain by caregiver's recall of previous 2 - 4 weeks. Symptom assessment for longer periods should reflect a global assessment such as inquiring whether the patient's asthma is better or worse since the last visit.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma control. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate poorer disease control. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have not-well-controlled asthma, even in the absence of impairment levels consistent with not-well-controlled asthma.
- Before step up in therapy:
  - Review adherence to medications, inhaler technique, and environmental control.
  - If alternative treatment option was used in a step, discontinue it and use preferred treatment for that step.

Reference:
Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma - Summary Report 2007
http://www.nhlbi.nih.gov/guidelines/asthma

FIGURE 8 - ASSESSING ASTHMA CONTROL AND ADJUSTING THERAPY IN CHILDREN 5 - 11 YEARS OF AGE

Components of Control		Classification of Asthma Control (5 - 11 years of age)		
		Well Controlled	**Not Well Controlled**	**Very Poorly Controlled**
Impairment	Symptoms	≤2 days/week but not more than once on each day	>2 days/week or multiple times on ≤2 days/week	Throughout the day
	Nighttime awakenings	≤1x/month	≥2x/month	≥2x/week
	Interference with activity	None	Some limitation	Extremely limited
	Short-acting $beta_2$-agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
	Lung function - FEV1 or peak flow - FEV1/FVC	>80% predicted/personal best >80%	60-80% predicted/personal best 75-80%	<60% predicted/personal best <75%
Risk	Exacerbations requiring oral systemic corticosteroids	0 - 1/year	≥2/year (see note)	
		Consider severity and interval since last exacerbation		
	Reduction in lung growth	Evaluation requires long-term followup.		
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		
Recommended Action for Treatment **(See Figure 5 for treatment steps.)**		- Maintain current step. - Regular followup every 1 - 6 months. - Consider step down if well controlled for at least 3 months.	- Step up at least 1 step and - Reevaluate in 2 - 6 weeks - For side effects: consider alternative treatment options.	- Consider short course of oral systemic corticosteroids, - Step up 1-2 steps, and - Reevaluate in 2 weeks. - For side effects, consider alternative treatment options.

Key: EIB, exercise-induced bronchospasm; FEV1, forced expiratory volume in 1 second; FVC, forced vital capacity

Notes:

- The stepwise approach is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.
- The level of control is based on the most severe impairment or risk category. Assess impairment domain by patient's/caregiver's recall of previous 2-4 weeks and by spirometry/or peak flow measures. Symptom assessment for longer periods should reflect a global assessment such as inquiring whether the patient's asthma is better or worse since the last visit.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma control. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate poorer disease control. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.
- Before step up in therapy:
  - Review adherence to medications, inhaler technique, environmental control, and comorbid conditions.
  - If alternative treatment option was used in a step, discontinue it and use preferred treatment for that step.

Reference:
Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma - Summary Report 2007
http://www.nhlbi.nih.gov/guidelines/asthma

FIGURE 9 - ASSESSING ASTHMA CONTROL AND ADJUSTING THERAPY IN YOUTHS ≥12 YEARS OF AGE AND ADULTS

Components of Control		Classification of Asthma Control (≥ 12 years of age)		
		Well Controlled	**Not Well Controlled**	**Very Poorly Controlled**
Impairment	Symptoms	≤2 days/week	>2 days/week	Throughout the day
	Nighttime awakenings	≤2x/month	1 - 3x/week	≥4x/week
	Interference with activity	None	Some limitation	Extremely limited
	Short-acting $beta_2$-agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
	FEV1 or peak flow	>80% predicted/personal best	60 - 80% predicted/personal best	<60% predicted/personal best
	Validated questionnaires ATAQ ACQ ACT	 0 ≤0.75* ≥20	 1 - 2 ≥1.5 16 - 19	 3 - 4 N/A ≤15
Risk	Exacerbations requiring oral systemic corticosteroids	0 - 1/year	≥2/year (see note)	
		Consider severity and interval since last exacerbation		
	Progressive loss of lung function	Evaluation requires long-term followup.		
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		
Recommended Action for Treatment **(See Figure 6 for treatment steps.)**		- Maintain current step. - Regular followup every 1-6 months to maintain control. - Consider step down if well controlled for at least 3 months.	- Step up 1 step and - Reevaluate in 2-6 weeks - For side effects, consider alternative treatment options.	- Consider short course of oral systemic corticosteroids, - Step up 1-2 steps, and - Reevaluate in 2 weeks. - For side effects, consider alternative treatment options..

*ACQ values of 0.76 - 1.4 are indeterminate regarding well-controlled asthma.

Key: EIB, exercise-induced bronchospasm; ICU, intensive care unit

Notes:

- The stepwise approach is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.
- The level of control is based on the most severe impairment or risk category. Assess impairment domain by patient's recall of previous 2-4 weeks and by spirometry/or peak flow measures. Symptom assessment for longer periods should reflect a global assessment, such as inquiring whether the patient's asthma is better or worse since the last visit.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma control. In general, more frequent and intense exacerbations (requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate poorer disease control. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have not-well-controlled asthma, even in the absence of impairment levels consistent with not-well-controlled asthma.
- Validated Questionnaires for the impairment domain (the questionnaires do not assess lung function or the risk domain)
  ATAQ = Asthma Therapy Assessment Questionnaire©
  ACQ = Asthma Control Questionnaire©
  ACT = Asthma Control Test™
  Minimal Important Difference: 1.0 for the ATAQ; 0.5 for the ACQ; not determined for the ACT.
- Before step up in therapy:
  - Review adherence to medication, inhaler technique, environmental control, and comorbid conditions.
  - If alternative treatment option was used in a step, discontinue it and use preferred treatment for that step.

Reference:
Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma - Summary Report 2007
http://www.nhlbi.nih.gov/guidelines/asthma

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