Louisiana Medicaid

Provider Update

Volume 26, Issue 4 **July/August 2009**

Message from the Medicaid Director

Jerry Phillips

After careful analysis of the state fiscal year 2009-2010 budget approved by the Legislature, Medicaid developed a plan for adjusting provider reimbursement rates in an effort to manage an $86 million-plus shortfall. Even with agency-initiated efficiencies, which helped to identify more than $100 million in budgetary funding, we were left with the prospect of cutting all Medicaid providers by over 7 percent. The Legislature budgeted additional funding to offset the proposed cuts; however, it was not enough to prevent cuts entirely.

This plan only attempts to address the appropriations shortage and to restore proposed rate adjustments identified during the session. Our official forecast of expenditures due by October 1st will provide the projected needs versus appropriation for this state fiscal year. At that time, we will evaluate the need for additional adjustments.

We discussed options with stakeholders and made strategic reductions to minimize the impact for both providers and recipients. For mandatory services (such as Hospitals and Physician Services), we are implementing strategic reductions that protect the Department's priorities: primary and preventative care and services to children.

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Emergency rules were issued in early August to reduce the reimbursement rates in the following programs:

- Adult Dentures
- Durable Medical Equipment
- Hospitals - Inpatient and Outpatient Services
- Laboratory and Radiology Services
- Long-Term Personal Care Services
- Inpatient Psychiatric Services
- Mental Health Rehabilitation
- Physician Services
- Medical Transportation - Emergency Ambulance
- New Opportunities Waiver

We are developing the methodology in a couple of other service areas to address needed reductions. We plan to revise our State Plan for the payment of hospice services. Also, hemodialysis providers presented a plan for a more efficient delivery of the services, which we are reviewing to determine if sufficient savings may be realized by this improvement.

While we worked expeditiously to develop a strategic plan for addressing the shortfall in the enacted budget, the earliest we could make these changes through the state rulemaking process was for an early August effective date. This means instead of the 12 months of savings, which were included in the Executive Budget, the proposed program reductions are not based on an entire year. Therefore, the amounts of cuts are greater because the needed savings must be achieved in a shorter time period.

These reductions, while unfortunate, are necessary to operate the Medicaid Program within available funding while making our best effort to preserve access to primary care for as many of our citizens as possible. Your ideas for making these reductions were considered and some were accepted. Please continue to provide us with your feedback on how to make adjustments that have minimal impact on the delivery of services and that allows us to meet our budget obligations.

Electronic Prior Authorization Changes

The electronic prior authorization (e-PA) web application has been updated. Providers now have the ability to modify information on a prior authorization request as many times as needed within 30 days before actually submitting the request to Unisys. Requests not submitted will expire in 30 days.

After the request has been submitted, providers will have 3 days to send in their attachments. If attachments are not received within 3 days, the request will be canceled by Unisys and a new request will be required. A prior authorization number will not be assigned to a request until attachments have been received.

Additional codes indicating the status of a request have been added to facilitate the confirmation process. Additional information regarding these changes can be obtained by viewing the on-line e-PA manual at www.lamedicaid.com.

New Dental Director Named for the Louisiana Medicaid Dental Prior Authorization Unit

Dr. David McKeon has recently been named the new Dental Director of the Louisiana Medicaid Dental Prior Authorization Unit. Dr. William Duvic will continue to serve as the Assistant Dental Director. Should you have any questions concerning the dental prior authorization process, please contact the unit at (866) 263-6534 or (504) 941-8206.

Dental Providers Required to Update Files

A recent federal review of the Louisiana Medicaid EPSDT Dental Program suggested the state make appropriate corrections to its dental provider files to allow the public better access to care. At least quarterly, providers should log on to www.lamedicaid.com under "Provider Login"

- to indicate whether or not they are accepting new Medicaid patients and
- to update their existing contact information.

This information from providers will be viewable to the public on the Department of Health and Hospital's website at http://www.dhh.louisiana.gov/offices/page.asp?id=92&detail=4931 using the Provider Locator Tool.

Instructions for creating an on-line account that will allow providers to update their information can be found by logging on to www.lamedicaid.com and then clicking the "Provider Web Account Registration Instructions" link. Questions concerning the Provider Web Account Registration process may be directed to Unisys at (877) 598-8753.

Providers are reminded to contact the Unisys Provider Enrollment Unit to report any change that may impact their enrollment status. Questions about changes that providers must report or the provider enrollment process should be directed to Unisys Provider Enrollment at (225) 216-6370.

TAKE CHARGE

The Medicaid TAKE CHARGE Program provides limited coverage for family planning services to women between the ages of 19-44 who do not meet Medicaid eligibility criteria, but who have family incomes up to 200% of the Federal Poverty Level.

Recipients of TAKE CHARGE are issued a distinct pink card which is used when verifying program eligibility through either the Medicaid Eligibility Verification System (MEVS) or Recipient Eligibility Verification System (REVS).

There are specific procedure codes and diagnosis codes that are approved for coverage under this program. While recipients may have multiple diagnoses at a visit, **claims must include one of the approved diagnosis codes in order to receive reimbursement**.

Before providing services to these recipients, providers of family planning services should

- check recipient eligibility,
- know what services are covered for this recipient population, and
- flag medical charts to indicate this is a TAKE CHARGE recipient.

Providers should never provide a non-covered service without informing the recipient that she will be responsible for payment if the non-covered service is provided.

For additional information about the limited services and diagnosis codes that are covered through this program, please go to www.takecharge.dhh.louisiana.gov.

Migraine Therapy

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Introduction

A migraine headache is a recurrent, disabling headache that impairs normal functioning in an individual. It is characterized by throbbing head pain sometimes accompanied by gastrointestinal, neurologic, and autonomic symptoms. From the American Migraine Study II, 18.2% of women and 6.5% of men reported experiencing one or more migraine headaches each year.[1] The highest prevalence of migraines in both men and women occurs between the ages of 35 and 45 years, with the onset occurring between the ages of 10 to 30 years of age.[2]

A migraine attack can be divided into several phases. Premonitory symptoms may occur hours to days before a migraine attack. These include neurological, psychological, and autonomic symptoms. Some migraine patients may also experience an aura. An aura consists of positive and negative focal neurologic symptoms that occur before or during a migraine attack, and usually lasts less than 60 minutes. Visual auras are most common and may be expressed as positive (e.g. flickering lights) or negative (e.g. loss of vision) features. The headache phase usually begins within 60 minutes of the end of the aura.[2]

Typically during a migraine attack, throbbing pain is experienced unilaterally in the frontotemporal regions. The onset of pain is gradual and can last from 4 to 72 hours. Many individuals experience nausea, vomiting, phonophobia, and photophobia. During the resolution phase following a migraine, patients may experience deep muscle aches, tiredness, and irritability. While patients do not have to experience all of the above symptoms to diagnose migraine, many suffer from a multitude of symptoms along with their migraine headache.[2]

Migraine Theories

Many theories have been proposed to explain the pathogenesis of migraines, but the exact etiology and pathophysiology are not completely understood. Based on the neurovascular theory, migraines are triggered by the activation of the trigeminal nucleus complex.[2] This activation triggers the release of vasoactive neuropeptides, including neurokinin A, substance P, and calcitonin-gene related peptide. These vasoactive neuropeptides promote intracranial extracerebral blood vessel vasodilation, leading to pain transmission to other CNS pathways. Central pain transmission may cause the associated symptoms of migraines, such as nausea, vomiting, photophobia, and phonophobia. Another theory suggests that a serotonin imbalance may result in the vasodilation of these intracranial extracerebral blood vessels leading to the activation of the trigeminovascular system.[2]

Migraine Criteria

Since headaches tend to be a very common complaint among patients, it is important for healthcare providers to properly identify migraine patients. Some patients may refer to a sinus or tension-type headache as a "migraine." Healthcare providers should properly distinguish between migraine headaches and these other common headaches in order to provide proper treatment, education, and care for the patient. The International Headache Society diagnostic criteria for migraines are shown in Table 1.[2]

Precipitating Factors

Patient-specific triggers may be identified and avoided for additional migraine prevention. Precipitating factors include certain foods and environmental, behavioral-physiologic, or medication-related triggers.

- Foods- alcohol, caffeine, chocolate, foods containing: monosodium glutamate (MSG), tyramine, nitrites, aspartame
- Environmental- flickering lights, high altitude, tobacco smoke
- Behavioral/physiologic- excess or insufficient sleep, fatigue, menstruation, stress, anxiety
- Medications- analgesic overuse, decongestant overuse, ergotamine overuse, estrogen therapy, nitrates, theophylline[2]

Goals of Migraine Management

When treating migraine headaches, certain therapy goals should be considered. The primary short-term goal of migraine treatment is to achieve rapid pain relief and allow the patient to resume normal activities. The long-term goal of therapy is prevention of headache recurrence and reduction of headache severity.[3] Other goals should include increasing the patient's quality of life, avoiding emergency care, and minimizing adverse effects of pharmacotherapy.

Migraine-specific agents, such as triptans, should be reserved for management of pain after analgesics have proven to be ineffective.[3] The non-oral route should be used to administer medication to patients with severe nausea or vomiting. Also, rescue medications such as analgesics and muscle relaxants should be considered for patients with severe migraines who do not respond to or fail other treatments.[4] Healthcare professionals must also guard against medication-overuse headaches in patients receiving treatment for migraines.[2] The desired outcome should always be patient satisfaction and improved pain management.

Current Treatment Options

There are several current treatment options available for migraine headaches. These include analgesics, vasoconstrictors (i.e. ergot alkaloids), and triptans. Analgesics should be tried and proven unsuccessful in the treatment of migraines before trying other drugs. Due to side effects and the potential for habituation, opioids should be a last resort for the management of migraine pain. Dihydroergotamine has been shown to be effective in some patients who may be unresponsive to triptans.[5] Triptans are migraine-specific agents and are commonly prescribed for migraine treatment. They inhibit neurotransmission in the trigeminal complex and activate serotonin 1b/1d pathways in the brain stem. They also decrease the release of vasoactive peptides which lead to vascular reactivity and pain. A patient should try at least two different triptans before being classified as triptan-unresponsive. Rarely, ischemic vascular events may occur due to the vasoconstrictive nature of these drugs. In patients with cardiovascular risks, the initial dose should be administered under practitioner supervision.[3] Treatment selection should be based on migraine severity and patient response (See Tables 2,3,4,5).

Possible Future Drug Selections

Telcagepant (MK-0974- Merck) is a calcitonin gene-related peptide(CGRP) receptor antagonist that is currently in phase III trials for intermittent use to abort migraines. CGRP receptors are widely distributed in sensory nerves in both the central and peripheral nervous systems. The exact role of this receptor in migraine pathophysiology still remains unclear; however, it does have vasodilatory activity, which is the most likely mechanism of action.[6] In a randomized, controlled, double-blind, parallel-treatment trial, telcagepant 300 mg was shown to be as effective as zolmitriptan 5 mg.[7] However, Merck has delayed filing an application with the FDA for telcagepant in 2009 after elevations in liver transaminases were found in patients using the drug twice daily for the prevention of migraines. Merck is also studying MK-3207, which is another investigational CGRP-receptor antagonist. It is currently in phase IIb of development and may start phase III trials later this year.[8]

Measures of Acute & Long-Term Success

Acute and long-term success can be measured by the length of pain-free status, reduction in the time of onset of symptom relief, and avoidance of emergency services. Long-term success can also be measured by the patient's control over the headache, improved quality of life, and increased productivity.[3] Once the patient achieves a prolonged headache-free interval, gradual dosage reduction or discontinuation of therapy may be possible.[2]

Conclusion

Since every migraine patient is unique, a headache diary may be beneficial to tailor treatments for the specific needs of individual patients. Patients should record dates, triggers, and pain severity for healthcare providers to select appropriate therapy. Also, it is important to obtain a thorough and complete patient work-up and history to assess patients for the treatment of migraines.

Using proper medication therapy and lifestyle modifications, migraine patients should be able to manage migraines and minimize the length of migraine disabilities. With the development of specific targeted therapies in the future, new medications may provide a more targeted treatment with minimal side effects for the disabling, recurrent migraine. Migraine patients with proper direction and assistance from their healthcare providers can have greater control over migraines than ever before.

Table 1: International Headache Society Diagnostic Criteria for Migraine[2]

MIGRAINE WITHOUT AURA

- Headache attacks last 4 to 72 hours
- Headache has at least two of the following characteristics:
  - o Pulsating quality
  - o Unilateral location
  - o Moderate or severe pain intensity
  - o Aggravation by or causing avoidance of routine physical activity
- During headache at least one of the following occurs:
  - o Nausea and/or vomiting
  - o Photophobia and phonophobia
- History, physical examination, and neurologic examination do not suggest any underlying organic disease
- **At least five attacks occur fulfilling the above criteria for migraine without aura**

MIGRAINE WITH AURA

- Migraine aura fulfills criteria for typical aura, hemiplegic aura, or basilar-type aura
- History, physical examination, and neurologic examination do not suggest any underlying organic disease
- **At least two attacks occur fulfilling the above criteria for migraine with aura**

TYPICAL AURA

- Fully reversible visual, sensory, or speech symptoms (but no motor weakness)
- Bilateral visual symptoms including positive features (e.g. flickering lights, spots or lines) or negative features (e.g. loss of vision) or unilateral sensory symptoms including positive features (e.g. pins and needles) or negative features (i.e. numbness), or any combination
- At least one of the following:
  - o At least one symptom that develops gradually over a minimum of 5 minutes or different symptoms that occur in succession or both
  - o Each symptom lasts for at least 5 minutes and no longer than 60 minutes
  - o Headache that meets criteria for migraine without aura begins during the aura or follows the aura within 60 minutes

Table 2- Analgesics for Migraine Treatment[2,3,9]				
Analgesics	**Daily Adult Dose**	**Max Daily Dose**	**Onset of Action**	**Precautions/Warnings**
Acetaminophen	1000 mg q 6 hrs prn	4000 mg	30 min	Hepatic disease
Aspirin 250mg / Acetaminophen 250 mg / Caffeine 65 mg	2 tabs q 6 hrs prn	8 tabs in 24 hours	30 min	Peptic ulcer disease, liver dysfunction
Ibuprofen	200-800 mg q 4-6 hrs prn	3200 mg	30 min	Significant renal dysfunction, bleeding disorders
Opioids (i.e., codeine, hydrocodone, propoxyphene, oxycodone)	Variable	Variable	Variable	Potential for habituation, depressed consciousness

Table 3-Vasoconstrictors for Migraine Treatment[2,3,9]			
Vasoconstrictors	**How supplied**	**Daily Dose**	**Contraindications**
Dihydroergotamine	1 mg/mL IM,SQ, IV injection	1 mL; repeat as needed q1h to total daily dose of 3 mL for IM or SQ or 2mL for IV in a 24h period	Coronary or other systemic vascular disease (e.g. HTN), use of CYP 3A4 inhibitors, severely impaired renal or hepatic function
	4 mg/ml nasal spray (0.5 mg/spray)	1 spray in each nostril; repeat in 15 min if needed; total dosage of 4 sprays	
Ergotamine tartrate	2 mg SL tablets	1 tab; then another after 30 min if still needed; max = 6 mg/day or 10 mg/week	Coronary or other systemic vascular disease (e.g. HTN), use of CYP 3A4 inhibitors, renal or hepatic disease
Isometheptene 65 mg / Acetaminophen 325 mg /Dichloralphenazone 100mg	65 mg/325 mg/ 100 mg capsules	2 capsules at once; then 1 capsule q1h until relieved or until the max dosage of 5 capsules in 12 hrs is reached	Glaucoma, coronary or other systemic vascular disease (e.g. HTN), severe renal disease, hepatic disease, or MAOI therapy

IM-intramuscularly, SQ-Subcutaneously, IV-intravenous, SL-Sublingual

Table 4- Triptans for Migraine Treatment[2,3,5,9]

Triptans	How Supplied	Max Daily Dose	Onset of Action	$T_{0.5}$ (half-life)	Notes
Sumatriptan	4 or 6 mg/0.5 mL injection 25, 50, or 100 mg tablets 5 or 20 mg nasal spray	12 mg 200 mg 40 mg	10-60 min	2 hrs	CIs include ischemic heart disease, other systemic vascular diseases, including uncontrolled HTN
Zolmitriptan	5 mg nasal spray 2.5 or 5 mg tablets 2.5 mg ODT	10 mg	10-60 min	2-3 hrs	Same CIs as above; Concentrations may be increased when used concurrently with propranolol
Naratriptan	1 or 2.5 mg tablets	5 mg	1-3 hrs	6 hrs	Same CIs as above; dose can be repeated once after 4 hours
Rizatriptan	5 or 10 mg tablets 5 or 10 mg ODT	30 mg	30-60 min	2-3 hrs	Same CIs as above; Lower doses needed when used concurrently with propranolol
Almotriptan	6.25 or 12.5 mg tablets	2 doses	30 min	3-4 hrs	Same CIs as above
Frovatriptan	2.5 mg tablets	7.5 mg	~ 2 hrs	~ 25 hrs	Same CIs as above
Eletriptan	20 or 40 mg tablets	80 mg	30-60 min	3-4 hrs	Same CIs as above; Concentrations may be increased when used concurrently with propranolol

CI-Contraindication, ODT-Orally disintegrating tablet

Table 5- Select Drugs for Migraine Prophylaxis[2,3,9]			
Prophylactic Drugs	**Side Effects**	**CIs/Warnings**	**Notes**
Beta-blockers (propranolol,* timolol,* metoprolol,** nadolol,** atenolol**)	Fatigue, depression, bradycardia	Decompensated heart failure; asthma	If results not seen in 4-6 weeks, need to taper off and try something else
Antiepileptics (valproic acid (VA), topiramate)	VA: nausea, fatigue, weight gain, tremor Topiramate: paresthesias, weight loss, taste perversions	VA: hepatic disease	Topiramate has 4 week titration
Tricyclic Antidepressants (amitriptyline)	Dry mouth, weight gain, sedation	MAOI therapy	Usual starting dose for migraines is 50-100 mg/d

* FDA approved for migraine prophylaxis
**Off-label indication for migraine prophylaxis

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