Louisiana Medicaid

Provider Update

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Budget Cuts Result in Reimbursement Reductions

After careful analysis of the state budget approved for fiscal year 2010 - 2011 by the Louisiana Legislature, the Department of Health and Hospitals (DHH) has developed a plan to manage a $168.1 million total budget reduction. This reduction equates to 4.6% of the enacted budget for the Medicaid Private Provider Program.

Language in the appropriations bill specifically noted that "savings shall be generated by the implementation of reductions to reimbursements for Medicaid services exclusive only of those services for which the payment methodology or minimum threshold is mandated in federal rules, regulations or law and that by reducing such reimbursements would jeopardize access in the Medicaid program." DHH worked with several provider groups and received many constructive suggestions in developing a plan that would comply with this legislative directive.

The reimbursement rates in the following service programs are scheduled to be reduced effective August 1, 2010 to meet the budget as approved for fiscal year 2010 - 2011:

Inpatient and Outpatient Hospital Services	Laboratory and Radiology Services
Ambulatory Surgical Centers	Non-Emergency Medical Transportation
Program for All Inclusive Care for the Elderly	Mental Health Rehabilitation
End Stage Renal Disease Facilities	Nursing Facilities
Family Planning Clinics & Waiver Program	Physician Services
Home and Community-Based Waiver Services	Long-Term Personal Care Services
Intermediate Care Facilities for Persons w/ DD	EPSDT Dental Services

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Emergency Rules which address these reimbursement reductions can be found online at the Office of State Register's website at http://www.doa.louisiana.gov/osr/reg/regs2010.htm under the August, 2010 link.

This plan only addresses the current shortages in the 2010 - 2011 budget. The official forecast of expenditures which is due by November 1, 2010 is expected to provide a more complete picture of projected needs versus appropriation for the entire fiscal year and could result in additional adjustments.

DHH's goal is to preserve access to primary care for as many citizens as possible while operating the Medicaid program within available funding. Providers' ideas played a critical role in this process, and continued provider feedback is encouraged.

DHH Moves toward Coordinated Care, Launches New Website

The Louisiana Department of Health and Hospitals (DHH) has launched a new website, www.MakingMedicaidBetter.com, to engage providers and enrollees in the state's efforts to improve its Medicaid delivery system with the implementation of Coordinated Care Networks (CCNs).

CCNs are entities designed to improve performance and health outcomes through an integrated healthcare delivery system for Medicaid/LaCHIP members by placing a stronger focus on quality, chronic care management and performance measures. Through the implementation of CCNs, Medicaid and LaCHIP will transition from the current fee-for-service system to a prepaid or shared savings model.

The prepaid CCN model, also known as a CCN-P, is comprised of licensed or certified entities that provide a **full range** of specified core benefits and health care services to members. The CCN-P receives a prepaid payment made on a per member per month (PMPM) basis. The CCN-P assumes the risk for the cost of services covered and may incur loss if the cost of furnishing services exceeds the payment received.

The shared savings model, also known as the CCN-S, uses a primary care case manager that provides enhanced primary care case management services which includes primary care providers (PCPs) and primary care management services. The CCN-S expands the roles and responsibilities of PCPs through the establishment of patient-centered medical homes and the creation of formal and distinct networks of PCPs to coordinate the full continuum of care. The CCN-S is paid a predetermined rate for the enhanced primary care case management services on a PMPM basis while Medicaid continues to pay all authorized claims on a fee-for-service basis.

Both models will be implemented simultaneously, with the current "go live" date of April 2011. The new models will be phased in over a 13-month period, with three regions activated at a time.

There are specified "carved-out" Medicaid services that members may obtain that the CCN is not responsible to provide. The CCN however is responsible for making all required referrals and assisting in the coordination of scheduling these services. Carved-out services include dental, pharmacy, hospice, behavioral health, specialized behavioral health, nursing home care, specified services in the DHH EarlySteps program, personal care, waiver, targeted case management and school-based Individualized Education Program (IEP) services. Carved-out services will continue to be paid for on a fee-for-service basis. DHH intends to integrate specialized behavioral health services into the prepaid networks approximately 24 months after implementation of the CCN.

Participation in a CCN will be mandatory for most Medicaid and LaCHIP members. Pregnant women will be mandatorily enrolled to have their care coordinated and to improve the state's infant mortality rates. Children receiving Supplemental Security Income (SSI), children in foster care, and children in out-of-home placement will be enrolled in CCNs but can request to remain in Medicaid fee-for-service. People over age 65, unless exempt, will also be enrolled in CCNs.

Providers are encouraged to visit the *Making Medicaid Better* website which includes a provider-specific portal on the following topics:

- Coordinated Care Network Overview
- Frequently Asked Questions (which is updated on a regular basis)
- Model Provider Agreements, and
- Document Library.

Comments regarding the CCNs or the provider agreements can be submitted online as well. The site also offers portals for Louisiana residents/Medicaid enrollees and potential CCNs.

For more information and regular updates, visit www.makingmedicaidbetter.com.

Avoid Hiring or Employing Excluded Individuals

As a condition of participation in the Louisiana Medicaid Program, providers are responsible for ensuring that current as well as potential employees have not been excluded from participation in the Medicaid or Medicare program by the Office of Inspector General (OIG). Providers who employ excluded individuals may be subject to penalties of $10,000 for each item or service the excluded individual furnished.

Providers should check the following two websites prior to hiring or contracting with an individual and should routinely check the websites for determining the exclusion status of current employees and contractors. All current and previous names used such as first, middle, maiden, married or hyphenated names and aliases for **all owners and employees** should be checked.

- http://exclusions.oig.hhs.gov/search.aspx
- http://www.epls.gov/epls/search.do

All Providers

If an individual's name appears on either website with a matching date of birth, this person is considered excluded and is barred from working with the Louisiana Medicaid program in any capacity. The provider must notify the Department of Health and Hospitals with the following information:

- Name of the excluded individual and
- Status of the individual (applicant or employee).

If the individual was an employee, the provider should also include the following information:

- Beginning and ending dates of the individual's employment with the agency,
- Documentation of termination of employment, and
- Type of service(s) provided by the excluded individual.

These findings should be reported to:

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

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.

Home and Community-Based Service Providers

License Renewals for Home and Community-Based Service Providers

The Department of Health and Hospitals' Health Standards Section (HSS) is responsible for processing annual license renewals for approximately 1600 home and community-based service (HCBS) providers licensed as a Personal Care Attendant (PCA), Supervised Independent Living (SIL), Respite, Family Support or Adult Day Care provider. Although license renewals are the responsibility of the provider, the HSS sends out between 100-200 notices each month reminding providers to renew their licenses.

Home and Community-Based Service Providers

As a courtesy, the HSS sends up to three license renewal notices to the provider. The first notice is sent 75 days prior to the expiration of the license. If the provider fails to respond to the first notice, a second notice is sent 30 days prior to the expiration of the license. If the provider fails to respond to the first two notices and the license expires, a final notice is sent to the provider via certified mail. The HSS will accept the provider's application and renewal fee if it is received within 10 days of receipt of the final notice; however, a $100 late fee will be assessed. When the license has not been renewed, HSS considers the license to be surrendered and will notify Molina Provider Enrollment that all Medicaid vendor numbers linked to the license should be closed.

Due to the large volume of license renewals that must be processed on a monthly basis, HSS will not accommodate providers who did not respond timely to renewal notices and then appear unannounced requesting their licenses be printed while they wait. In order to assure timely issuance of a new license, **the license renewal application and fee should be received by the HSS at least 14 days prior to the expiration date of the current license**.

Long-Term Care Facilities

Facility Notification System Expanded

The Facility Notification System which enables long-term care facilities to submit electronic notifications of recipient admissions, transfers, status changes, discharges or death to the Department of Health and Hospitals has been expanded. Facilities can now access the Long Term Care Patient Liability Adjustment Form (148-PLI) through the Facility Notification System.

The addition of the 148-PLI to the Facility Notification System allows providers a quick method for notifying the Medicaid office of the recipient's Patient Liability Income changes or errors. Specific instructions for accessing and completing the 148-PLI can be found by clicking on the "User Manual" link on the Facility Notification System website at https://bhsfweb.dhh.louisiana.gov/DHH148/.

Facilities that have not already obtained access to the system should download and complete a Confidentiality Responsibilities/Agreement form for all staff involved with the submission and retrieval of Medicaid forms. The original form should be submitted to:

Medicaid - Eligibility Systems Section
P. O. Box 91283
Baton Rouge, LA 70821-9283

Notification of authorization will usually be made via e-mail within two working days. For additional information, facilities should refer to their provider notice dated June 11, 2010 or call Medicaid at (225) 342-6398.

Nursing Facilities and Hospital-Based Skilled Nursing Units

Changes in Certification Requirements for Nurse Aides Employed in Nursing Facilities or Hospital-Based Skilled Nursing Facilities

Effective August 15, 2010, certified nurse aides (CNA) who are employed or contracted by a nursing facility or hospital-based skilled nursing facility (SNF) to provide nursing assistant services must have a current valid registration with the Louisiana Certified Nurse Aide Registry. The Department of Health and Hospitals (DHH) will initially provide automatic registration of all certified nurse aides in Louisiana who according to the Louisiana Nurse Aide Registry are employed with or contracted by a nursing facility or hospital-based SNF on August 15, 2010. Providers seeking to employ or contract with a CNA after August 15, 2010 will be responsible for verifying the CNA's current state registration.

In order to maintain certification, CNAs who work in a nursing facility or hospital-based SNF must perform a minimum of **90 days or 720 hours of CNA duties in one nursing facility within a 120 day period each year**. DHH will confirm the completion of the required hours at least once every two years, and CNAs not meeting this requirement will be designated as "not certified" and "unregistered" on the Registry.

The certification requirements for aides working in approved settings **other than nursing facilities or hospital-based SNFs** remain the same.

Information regarding these requirements can be found by reviewing Louisiana Revised Statutes 40:2120.51 through 40:2120.57 on the Louisiana State Legislature website at http://www.legis.state.la.us. Links will also be added to the Health Standards Section and Louisiana Certified Nurse Aide Registry websites to provide information on these requirements.

Questions regarding this change may be directed to the Health Standards Section at (225) 342-0138 or the Louisiana Certified Nurse Aide Registry at (225) 295-8575.

Nursing Facility Providers

Nursing Facility Capital Re-Age Requests

All nursing facility providers are required to file a "Nursing Facility Case-Mix Fair Rental Value Re-Age Request" form anytime there is a change in licensed beds. This form, which is also referred to as a capital re-age request form, must indicate the:

- Effective date of the change,
- Increase/decrease in the number of licensed beds, and
- Change in the facility's square footage associated with the licensed bed change.

Nursing Facility Providers

A copy of this form and the associated memorandum are available to providers online at http://www.dhh.louisiana.gov/offices/publications.asp?ID=111&Detail=2433. Providers must send the completed form along with the supporting documentation to:

Myers and Stauffer, LC
Attn: Louisiana NF
11440 Tomahawk Creek Parkway
Leawood, KS 66211

Any questions concerning the form or the memorandum should be directed to Myers and Stauffer by calling 1-800-374-6858 or by sending an e-mail to lanf@mslc.com.

Professional Services Providers and Hospitals

Electronic Health Record Incentive Payment Program

The nation's healthcare system is undergoing a transformation in an effort to improve quality, safety and efficiency of care through use of information exchanges by electronic health record (EHR) technology. To facilitate this vision, the Health Information Technology for Economic and Clinical Health (HITECH) Act established programs under Medicare and Medicaid to provide incentive payments for the "meaningful use" of certified EHR technology.

In coordination with this effort, Louisiana Medicaid is developing an EHR incentive program to provide incentive payments to eligible professionals and hospitals as they implement, upgrade and demonstrate meaningful use of certified EHR technology. The program is scheduled to begin in 2011 and will operate through 2021. The incentive program is designed to support providers in this period of health information technology transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety and efficiency of patient health care. For more information, visit the Centers for Medicare and Medicaid Services website at http://www.cms.gov/EHRIncentivePrograms. State-specific information will be placed on the Louisiana Medicaid website, www.lamedicaid.com, as it becomes available.

Remittance Advice Corner

The following messages were transmitted to providers through Remittance Advices (RA) during May and June 2010:

Attention Professional Services Providers
Error with Implementation of August 4, 2009 Rate Reductions

It has come to our attention that some claims that processed on the RA of May 25, 2010 were reimbursed referencing the wrong fee on file. This was in conjunction with the rate reductions implemented last week for dates of service beginning on 8/4/2009. The affected claims are identified as those with Evaluation and Management codes for children 0 through 15 years of age. The programming logic has been updated and the reimbursement of future claims beginning with the RA of 6/1/2010 will not be affected by this error. Claims that reimbursed erroneously on the RA of 5/25/2010 will be systematically adjusted and appear on the RA of 6/8/2010. No action is required by providers.

Please note that the claims to be adjusted on the RA of 6/8/2010 for the above mentioned error will once again be adjusted in the near future. These future adjustments are the result of the delayed implementation of rate reductions for DOS beginning 1/22/2010 which are set to impact services delivered to children 0 through 15 years of age. Implementation of these edits later in June will result in services to children in that age group being reimbursed at 90% of 2009 Region 99 Medicare fees. Providers should continue to monitor RAs and www.lamedicaid.com for status updates. Providers should continue to contact the Provider Relations unit at (800) 473-2783 or (225) 924-5040 with questions related to the implementation of the rate reductions.

Attention Professional Services Providers
Re: August 4, 2009 Rate Reductions
Systematic Adjustment of Claims Adjudicated Prior to Implementation

Providers will see adjustments to their weekly RA's for claims with dates of service Aug. 4, 2009-Jan. 21, 2010 that were adjudicated prior to May 25, 2010. These claims will be systematically adjusted over a period of 16 weeks in numerical order by the original date of adjudication. No action is required by providers. The adjusted claims for each billing provider will appear on multiple RA's beginning with the RA of June 8, 2010. Claims can be identified as having an ICN beginning with 0149 and 1050. Providers are encouraged to continue to monitor their RA's and the LA Medicaid website at www.lamedicaid.com for updates regarding the rate reductions, updates to the Professional Services Fee Schedule, and a supplement to the fee schedule detailing procedure codes affected by the reductions. Please contact the Provider Relations unit at (800) 473-2783 or (225) 924-5040 with questions concerning the rate reductions or adjustments.

ClaimCheck Denials Related to Modifier 51

Providers who have received ClaimCheck denials for error 934 (Modifier 51 Required-ClaimCheck) and 938 (Modifier 51 Invalid-ClaimCheck) are asked to briefly delay resubmission of these claims to prevent inadvertent additional denials. The necessary updates to the claims processing system that will allow the resubmitted claims to properly process are being addressed and tested. It is anticipated that these updates will be complete in the next few weeks. Providers will be notified when claims for these errors can be resubmitted. Please use the blue ClaimCheck link on the Medicaid website, www.lamedicaid.com, for the most current information on ClaimCheck. For questions related to this matter, please contact Molina Medicaid Solutions Provider Relations at (800) 473-2783 or (225) 924-5040.

ClaimCheck Impact to Billing of Preventive Screening and Office Visit

With the implementation of ClaimCheck on date of processing May 17, 2010, a change is being made that may directly impact providers. In circumstances where a child has a KIDMED screening, a suspected condition is identified, and the child must be referred in-house for a "sick" visit on the same date of service, the "sick" visit procedure code 99212 MUST be accompanied by the 25 modifier. Following ClaimCheck implementation, absence of the 25 modifier will cause claims to deny. Providers should take the necessary steps within their system or procedures to ensure that the 25 modifier can be appropriately placed on these claims.

Rehab Centers, Ambulance Transportation, KIDMED Screening Clinics, DME, Mobile X-Ray/Radiation Therapy Centers & Optical Suppliers

It has come to our attention that some claims that processed on the RAs of 5/25/10, 6/1/10, 6/8/10 and 6/15/10 were reimbursed referencing the wrong fee on file as a result of the implementation of rate changes for professional services providers. The fees and programming logic have been updated. The reimbursement of future claims will not be affected by this error. Claims that reimbursed erroneously on the RAs previously mentioned will be systematically adjusted in the near future. No action is required by the providers. Providers are encouraged to continue to monitor their RAs for these adjustments and the LA Medicaid website (www.lamedicaid.com) for a detailed list of the codes impacted. Please contact the Provider Relations Unit at (800) 473-2783 or (225) 924-5040 with questions concerning the error and adjustment of claims.

Audiology Service Providers

Programming logic has been updated for audiology procedure codes 92540, 92550, and 92570 effective for date of service January 1, 2010 forward. Claims that previously denied with error code 210 "PROVIDER NOT CERTIFIED FOR THIS PROCEDURE" will be systematically adjusted and will appear on the RA on June 29, 2010. No action is required by providers.

Online Medicaid Provider Manual Chapters

The following Medicaid Provider Manual Chapters are available on the Louisiana Medicaid website at www.lamedicaid.com under the "Provider Manual" link.

- American Indian 638 Clinics
- Dental
- Family Planning Waiver (Take Charge)
- Mental Health Clinics
- Mental Health Rehabilitation
- Multi-Systemic Therapy
- Personal Care Services
- Pharmacy
- Psychological Behavioral Services

This list will be updated periodically as other Medicaid program chapters become available online.

Urinary Incontinence of Adults

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INTRODUCTION

Urinary incontinence (UI), defined as "the complaint of any involuntary leakage of urine" is a common condition seen most often in the adult population. The highest incidence occurs in those > 65 years of age, affecting more than 60% of individuals residing in long-term care facilities. Women are affected by UI more often than men, and only about half of patients affected with UI seek treatment for their symptoms. Even though many effective treatment options are available, undertreatment may be the result of social stigma, ignorance regarding treatment availability, or a belief that incontinence is a normal part of the aging process. Correctly identifying and treating UI can significantly improve a patient's quality of life.

CLINICAL PRESENTATION

Urinary continence is accomplished by the coordinated efforts of the smooth muscle of the bladder (detrusor muscle) and the bladder neck, which is comprised of a mixture of bladder and urethral smooth muscle, and the skeletal muscle of the outlet sphincter (rhabdosphincter). The storage and voiding of urine is the responsibility of the lower urinary tract. Normal urine storage requires a relaxed detrusor muscle and a contracted outlet sphincter whereas opposite conditions apply in the voiding phase in order to expel urine. Continence is maintained as long as the urethral sphincter pressure exceeds the intra-abdominal pressure generated by the detrusor muscle and the weight of other abdominal organs. If the sphincter is not fully closed, even minor increases in abdominal pressure (e.g., a cough or sneeze) can result in incontinence. Furthermore, even if the outlet sphincter is fully functional, very forceful and involuntary detrusor spasms can result in feelings of urgency and cause urine leakage.

Incontinence can result from direct injury to the muscles that regulate the storage of urine or injury to the sympathetic or parasympathetic pathways that innervate and regulate the muscles of the urinary tract. Dysfunction in any of the neuronal innervations of the urinary system can result in incontinence as well. Physical injury could result from childbirth or surgical trauma, while neuronal dysfunction is most often due to neurodegenerative diseases or strokes. UI classification depends on the type and location of dysfunction present. The two major types of UI are urge urinary incontinence (UUI), which is mainly due to bladder dysfunction, and stress urinary incontinence (SUI), which is due to dysfunction of the bladder outlet sphincter. A combination of urge and stress incontinence symptoms is called mixed incontinence. Another type of incontinence, functional incontinence, is less dependent on urinary tract function and is more related to neuronal factors such as decreased mental capacity or mobility secondary to stroke or injury. Risk factors for urinary incontinence may include: increasing age, multiparity, obesity, diabetes, dementia, and stroke. Medications can also contribute to the symptoms of incontinence, usually as a side effect of their therapeutic action. Alpha-blockers, used to treat benign prostatic hyperplasia and hypertension, are associated with UI in men.

They may cause the urethral smooth muscle to relax to such an extent that urine may leak, leading to new or additional UI symptoms. Medications that may aggravate an existing condition by increasing urine production include caffeine, alcohol, diuretics, and angiotensin converting enzyme inhibitors. Medications with central nervous system (CNS) effects (e.g., sedatives, hypnotics, and other sleep aids) can decrease a patient's mobility and awareness of their need to urinate and may lead to incontinence symptoms. Cholinergic or anticholinergic medications, which increase or decrease detrusor contractility, respectively, interfere with the normal function of the bladder. It is important to be aware of these medications to ensure they are not an underlying cause for patient symptoms. For more information on medications influencing lower urinary tract function, see Table 1.

Table 1. Medications Influencing Lower Urinary Tract Function

Medication	Effect
Diuretics	Polyuria, frequency, urgency
Alpha-receptor antagonists	Urethral relaxation and stress urinary incontinence in women
Alpha-receptor agonists	Urethral constriction and urinary retention in men
Calcium channel blockers	Urinary retention
Narcotic analgesics	Urinary retention from impaired contractility
Sedative hypnotics	Functional incontinence caused by delirium, immobility
Antipsychotics	Anticholinergic effects and urinary retention
Anticholinergics	Urinary retention
Antidepressants, tricyclic	Anticholinergic effects, alpha-antagonist effects
Alcohol	Polyuria, frequency, urgency, sedation, delirium
Angiotensin-converting enzyme inhibitors (ACEIs)	Cough as a result of ACEIs may aggravate stress urinary incontinence by increasing intra-abdominal pressure

UUI, commonly known as overactive bladder, is defined as a leakage of urine associated with the sudden, strong desire to void. It is a result of detrusor muscle dysfunction and usually occurs when the detrusor muscle contracts inappropriately during the bladder filling or urine storage phase. Drug therapy with anticholinergic medications, specifically antimuscarinics, reduces the effect of detrusor muscle neuronal stimulation and is the standard of treatment for UUI. SUI is the result of weakness or failure of the urethral rhabdosphincter or pelvic floor muscles and occurs when there are sudden increases in intra-abdominal pressure in the absence of detrusor contractility. Some conservative treatments for myogenic SUI are pelvic floor muscle exercise and bladder training, while more extreme treatments involve electrical stimulation or surgical repair. Neuropathic SUI involves a failure of the neuronal innervations of the urinary outlet sphincter. The sphincter can experience partial or complete flaccid paralysis leading to involuntary urine loss which may be due to neurodegenerative diseases (e.g., Alzheimer's disease, multiple sclerosis, or stroke).

TREATMENT

There are many pharmacologic and non-pharmacologic treatment options available for UI. Non-pharmacological treatments include lifestyle and behavioral modifications. Anticholinergics are the mainstay of UI treatment, though other prescription agents such as duloxetine, imipramine, and alpha-antagonists are also available. In most cases, surgical interventions are considered when other alternatives have failed.

Non-Pharmacologic Treatments

Lifestyle/Behavioral Modifications

Initial non-pharmacologic therapy calls for weight loss, pelvic floor muscle training (PFMT), bladder training, and the use of absorbent products. These options are favorable because they are simple and easy processes, inexpensive, and noninvasive in nature. Weight loss will reduce the pressure on the bladder and is a healthy way to improve SUI in overweight or obese patients. Strengthening the urethral sphincter and associated muscles with PFMT is a common initial method. These exercises have been shown to have a greater treatment effect in younger women with only SUI. These maneuvers, commonly referred to as Kegel exercises, have been shown to increase cure rates seven-fold. However, patients must be adherent for three to four months to see improvement. Bladder training and timed voiding use a structured time schedule to gradually increase the duration of time between voiding episodes. Restriction of fluids and of caffeine may help reduce incontinence symptoms. Mental distraction or relaxation exercises are urge suppression techniques that are beneficial for those with UUI. Additionally, absorbent products, such as specially designed undergarments, protective briefs, or adult diapers may be utilized but are not curative. Pharmacological treatment options and conservative treatments, such as biofeedback, neuromodulation, pessaries, and PFMT, should be utilized and deemed unsuccessful prior to considering surgery. Biofeedback utilizes PFMT and computer technology to help track bladder and urethral muscle activity. Neuromodulation, a method similar to PFMT, entails administering brief doses of electrical stimulation to strengthen the pelvic floor muscles. Biofeedback and neuromodulation techniques help with both SUI and UUI; however, long-term benefits are questionable. Pessaries are specialized vaginal inserts for adult females and are often used to treat vaginal or rectal prolapse. Pessaries work by elevating the uterus and bladder, resulting in decreased SUI symptoms.

Surgery

Surgery is generally recommended only after other treatments have failed to alleviate incontinence. Bladder repositioning involves pulling the urethra to a higher or more normal position to improve SUI. Slings are also used to aid the deficient pelvic floor muscle by providing a hammock-like support under the urethra. Slings can also be used in males who have UI due to prostate cancer treatment.

Anticholinergics

Anticholinergics work to relieve UI by reducing detrusor contractions stimulated by acetylcholine and are effective in UUI. Immediate-release (IR) oxybutynin is the first choice for UUI and is the standard for which other drugs are compared. Though an oxybutynin extended-release (ER) formulation is available, newer, once-daily uroselective anticholinergics may be more favorable. The newer agents (tolterodine, darifenacin, solifenacin, trospium, and fesoterodine) have an improved side effect profile with comparable efficacy to oxybutynin.

Common anticholinergic side effects include constipation, dry mouth, blurred vision, and gastrointestinal (GI) disturbances. Sedation and confusion may also occur. Side effects may be increased if used concomitantly with medications also having anticholinergic properties. Patients should be monitored for signs of CNS effects, especially during initiation of therapy or after dose increases. Particular caution is necessary when treating the elderly due to their increased sensitivity to side effects from these agents. Contraindications to anticholinergics include urinary retention, gastric retention and other severe GI motility conditions, and uncontrolled narrow-angle glaucoma.

The use of IR oxybutynin and darifenacin are associated with the most frequent incidence of side effects. The oxybutynin transdermal patch has been shown to have the lowest rates of dry mouth and constipation when compared to other anticholinergics. However, in the same study, approximately 15% of patients reported dermatologic reactions with transdermal patch use. Topical products should be applied to clean, dry intact skin. The site of application should be rotated. It is recommended not to bathe, shower or swim until one hour after gel application.

Tolterodine ER has the best tolerability profile, but solifenacin may be a more efficacious agent when compared to IR tolterodine. Compared to placebo, effectiveness of darifenacin may be decreased in patients greater than 65 years old, additionally increased rates of side effects may occur with solifenacin in this age group.

Alternative Agents

Duloxetine is a serotonin and norepinephrine-reuptake inhibitor thought to facilitate sphincter contraction and allow the bladder to relax, increasing sphincter outlet resistance. It has been approved for SUI in some European countries, but is not approved by the Food and Drug Administration for this indication. Common side effects include nausea, fatigue, dry mouth, constipation, and hyperhidrosis. Imipramine is a tricyclic antidepressant which reduces detrusor contractility and tone and has been used for urinary incontinence. Clinical trials of the efficacy of intravesical botulinum toxin A in the treatment of urinary incontinence are ongoing.

Conclusion

The causes of UI are multifactorial and include trauma, aging, childbirth, and neurologic disorders. The condition is underreported as well as undertreated. Appropriately identifying the cause and type of UI is vital to selecting the most appropriate treatment.

Table 2 - Pharmacotherapy

Product	Typical Strengths*	Usual Dosage Range (Adult)**
Oxybutynin (Ditropan®, Ditropan XL®, Oxytrol® GelniqueTM)	Ditropan®: 5 mg Ditropan XL®: 5 mg, 10 mg, 15 mg Oxytrol®: 3.9 mg/day GelniqueTM: 10%	Ditropan®: 2.5 mg to 5 mg BID-QID Ditropan XL®: 5 mg to 15 mg QD Oxytrol®: 1 transdermal patch twice weekly GelniqueTM: Apply contents of sachet QD
Tolterodine (Detrol®, Detrol LA®)	Detrol®: 1 mg, 2 mg Detrol LA®: 2 mg, 4 mg	Detrol®: 1 mg to 2 mg BID Detrol LA®: 4 mg QD
Darifenacin (Enablex®)	7.5 mg, 15 mg	7.5 mg to 15 mg QD
Solifenacin (VESIcare®)	5 mg, 10 mg	5 mg to10 mg QD
Trospium (Sanctura®, Sanctura® XR)	Sanctura®: 20 mg Sanctura® XR: 60 mg	Sanctura®: 20 mg BID Sanctura® XR: 60 mg QAM
Fesoterodine (ToviazTM)	4 mg, 8 mg	4 mg to 8 mg QD

*Consult prescribing information for available dosage forms.

**Consult prescribing information for dosage adjustments in patients with renal and/or hepatic impairment.

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