Louisiana Medicaid

Provider Update

Volume 23, Issue 5 **September/October 2006**

TAKE CHARGE

FAMILY PLANNING WAIVER PROGRAM

TAKE CHARGE is a family planning waiver program implemented October 1, 2006 to offer services to uninsured women ages 19-44 with family incomes below 200% of the federal poverty level. The waiver program, capped at 75,000 enrollees in the first year, is designed to increase access to family planning and reduce unintended pregnancies.

All **TAKE CHARGE** enrollees will have a **pink** identification card. Eligibility can be verified by swiping the card or calling the Recipient Eligibility Verification System (REVS). The telephone number for the (REVS) will be listed on the back of the identification card.

TAKE CHARGE covers a defined set of services. Codes approved for use under the waiver will be made available to providers through provider manuals and on www.lamedicaid.com. Services include the following:

- Yearly physical examinations and/or necessary re-visits (codes include: 99201-99205, 99211- 99215, and 99241-99245) NOTE: **There is a limit of FOUR office visits per calendar year for these services.**
- Laboratory tests related to family planning.
- Pharmaceuticals and supplies (i.e., birth control pills, patches, injections, IUD's, diaphragms, etc.) which are currently covered by Medicaid.
- Voluntary sterilization procedures are also covered.

Additional information about **TAKE CHARGE** can also be found at:
www.TAKECHARGE.DHH.Louisiana.gov.

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Implementation of Revised Health Insurance Claim Forms CMS-1500 (08/05) and UB-04

The Office of Management and Budget (OMB), the National Uniform Claim Committee (NUCC), and the National Uniform Billing Committee (NUBC) have given their stamp of approval to the new CMS-1500 Health Insurance Claim Form (version 08/05) and the new UB-04 Claim Form.

CMS-1500 (08/05) Health Insurance Claim Form:

Provider Types Affected

Providers affected by this change are physicians, health care professionals and suppliers who bill Louisiana Medicaid for their services using the Form CMS-1500.

Implementation Period

The Form CMS-1500 (08/05) version will be accepted January 1, 2007, but will not be mandated for use until April 2, 2007.

Providers will be permitted to use either the current Form CMS-1500 (12/90) version or the revised Form CMS-1500 (08/05) version beginning January 1, 2007 through April 1, 2007. Health plans, clearinghouses, and other information support vendors should be able to handle and accept the revised Form CMS-1500 (08/05) by January 2, 2007.

Effective April 2, 2007, the current Form CMS-1500 (12/90) version of the claim form will be discontinued and only the revised Form CMS-1500 (08/05) shall be used. This includes all rebilling of claims even though earlier submissions may have been on the current Form CMS-1500 (12/90).

Providers should not submit the revised 1500 Form prior to January 1, 2007 or the current Form after April 1, 2007. Claims billed in this manner will be rejected and returned to the provider.

Key Points

Complete instructions for Louisiana Medicaid claim submission on the new CMS-1500 Form for each provider type will be made available at a later date on www.lamedicaid.com.

- The new Form accommodates the reporting of the National Provider Identifier (NPI) as well as several other changes.*
- A major difference between Form CMS-1500 (08/05) and the prior Form CMS-1500 is the **split provider identifier fields.** The split fields will enable NPI reporting in the fields labeled as NPI, and corresponding 7-digit Louisiana Medicaid Number reporting in the unlabeled block accompanying each NPI field.
- Providers must continue to use their 7-digit Medicaid Provider IDs.
  Once NPIs are mandated, providers will be required to enter both the 7-digit Medicaid Provider ID and NPI.

- Field 17a of the new CMS-1500 will continue to be utilized by Louisiana Medicaid for the current CommunityCARE PCP Referral Authorization Number when appropriate.
- The gray area of Field 24D of the new CMS-1500 will be utilized by physicians to place NDCs for drugs and biological. Instructions regarding billing requirements for use of NDC codes will be forthcoming.
- Field 24C of the revised Form will become the emergency indicator (EMG). The CommunityCARE emergency indicator entered in field 24I of the current Form should be entered in 24C of the revised Form if applicable.

* NOTE: To prepare for full implementation of NPI, providers must go to the NPI registration application in the Provider Applications area of www.lamedicaid.com (click the **Provider Login** button, follow standard login procedures, and select the NPI application). Registering the NPI in this way will ensure that Unisys computer systems will have a cross reference between the provider's NPI and the provider's Louisiana Medicaid ID number.

UB-92 and UB-04 Claim Forms

The UB-92 Claim Form is being replaced by the UB-04 Claim Form beginning March 1, 2007. Providers will be permitted to use either the UB-92 or the UB-04 beginning March 1, 2007, through May 22, 2007. Beginning May 23, 2007, only the UB-04 will be accepted. Further details and instructions will be made available to providers as the date for implementation of the UB-04 nears.

More Assistance

Please continue to check future remittance advice messages and www.lamedicaid.com for additional information on instructions for use of the new billing Forms. Information on how to obtain a supply of the new Forms and other helpful information can be found at www.nucc.org for the CMS-1500. Information is available at www.nubc.org for the UB04; however, you must be a subscriber to obtain specific data from this website.

Update
National Provider Identifier

The National Provider Identifier (NPI) is a ten digit number mandated by HIPAA for healthcare providers that will be required on all standard electronic transactions by May 23, 2007. The deadline is May 23, 2008 for small health plans. In addition, Louisiana Medicaid will require the use of an NPI on paper claims by May 23, 2007. More instructions on the use of NPI on paper will be forthcoming.

All healthcare providers should register for a NPI now.

To request an NPI, providers should contact the National Provider Plan Enumeration System (NPPES) either online through their website at https://nppes.cms.hhs.gov or by calling their Help desk at **1-800-465-3203.**

Pharmacy providers can have their NPI request submitted and processed by the National Council for Prescription Drug Program (NCPDP) or register through NPPES.

Louisiana Medicaid expects providers to request an NPI for each of their current Medicaid Providers IDs whenever possible. The primary reason for this recommendation is to assist the fiscal intermediary (FI) in building the best possible cross-walk file from the NPI to the current Medicaid Provider ID which will continue to be used for internal processing and claims payment.

The Louisiana NPI Registration application currently only allows registrations that are of a one-to-one relationship; one NPI to one Louisiana Medicaid Provider ID. If you find that due to very specific circumstances you are unable to request an NPI for each Louisiana Medicaid Provider ID, you will be asked to contact the Louisiana NPI Assistance group to discuss your particular issue. The Louisiana NPI Assistance group can be contacted at email address lamedicaidNPI@Unisys.com or at **(225) 216-6400**.

You must register your NPI with Louisiana Medicaid so that we can cross-walk the new NPI to your Louisiana Medicaid ID. To register the NPI, go to the secured area of the www.lamedicaid.com where you will find an application link called NPI. Please note that group practices must register each individual doctor's NPI as well as the group's NPI with Louisiana Medicaid. Additional information on NPI can be located at the following websites or telephone numbers:

• CMS HIPAA hotline	**1-866-282-0659** or www.cms.hhs.gov
• NPI hotline	**1-800-465-3203 or 1-800-692-2326** (NPI TTY)
• NPI website	www.foxsys.com/npi.htm
• NPPES	https://nppes.cms.hhs.gov
• LAMedicaid	www.lamedicaid.com
• Washington Publishing	www.wpc-edi.com for specific information on Taxonomy Codes

We thank you again for your help in making this a smooth transition.

Medicare Fights Against New Schemes to Defraud Beneficiaries

The following information was recently published on the Centers for Medicare & Medicaid Services Website.

Recently the Centers for Medicare & Medicaid Services (CMS) issued a new consumer alert regarding the "$299 Ring" -a scheme to defraud seniors and people with disabilities. Under this scheme, callers contact Medicare beneficiaries promising a new prescription drug card for a flat fee of $299 and request beneficiary's bank account numbers that are then used to electronically withdraw the money.

CMS has learned that a new variation on the scheme requests higher dollar amounts and promises a new Medicare card, instead of a prescription drug plan. The dollar amount now requested by phone is usually $379, but in some cases callers have asked for $350 or $365. Medicare has already referred nearly 250 cases involving attempts to steal beneficiaries' funds to federal law enforcement officials.

The new Medicare card or prescription drug plan they claim to be selling is not legitimate. Callers may use the names of fictitious companies, such as **Pharma Corp., National Medical Office, Medicare National Office or National Medicare.**

To protect all people from being victimized, steps are being taken to prevent, identify and help law enforcement officials apprehend these scam artists. You may want to share this information with your patients or refer them to the contact number at 1-877-7SAFERX **(1-877-772-3379)** to report a complaint or if they feel they may have already become a victim.

The Direct Service Worker Registry

Act 306 of the 2005 Regular Legislative Session authorized the Department of Health and Hospitals to establish and maintain a registry of direct service workers and to adopt provisions for defining minimum mandatory qualifications and requirements for direct service workers. Management of the direct service worker registry will be handled by the Health Standards (HS) Section.

HS is working diligently to get the registry up and running. As part of this effort, training curriculums for those agencies that choose to do their own training will need to be submitted to HS for approval. The curriculums will be accepted effective October 1, 2006. Within the next month HS will post additional information on its web site to assist providers with curriculum submission and workers registration.

Questions regarding the registry may be directed to the program desk at **225-342-5794**.

RA Message Corner

Billing for Services Related to Non-Covered Services

Louisiana Medicaid does not pay for provision of services related to a non-covered service. An example of this inappropriate billing situation would be billing for local anesthesia provided during a routine circumcision of a newborn. Neither of these services, in this instance, is reimbursable under the Louisiana Medicaid Program. Payments received for non-covered and related services are subject to recoupment.

Sterilization Consent Forms

Providers may continue to use the sterilization consent form available from the Office of Population Affairs (OPA) and their website after the date listed on the current form. OPA is having an updated consent form printed that should be available by the end of the year. Providers are strongly encouraged to use the most up-to-date form available. The OPA website is: http://opa.osophs.dhhs.gov/pubs/publications.html.

Use of Unlisted CPT Codes for Gastric Bypass Surgery

Effective immediately, providers should use the appropriate CPT code when submitting prior authorization requests and claims for gastric bypass surgery. Submissions using an "unlisted" procedure code when there is a valid CPT code for the procedure will be **denied.**

Contact Information

TOLL FREE NUMBERS AVAILABLE FOR RECIPIENTS

To contact the Office for Citizens with Developmental Disabilities (OCDD) or for information on the New Opportunities Waiver (NOW) or Children's Choice Waiver services, callers should dial **1-866-783-5553.**

To contact the Office of Aging and Adult Services (OAAS) or for information on the Long Term Personal Care Services (LTPCS), Elderly and Disabled Adult (EDA) Waiver or Adult Day Health Care (ADHC) Waiver services, callers should dial **1-866-758-5035**.

To contact the Health Standards Section to file a formal complaint against a direct service provider or support coordinator, callers should dial **1-800-660-0488**.

For assistance related to Specialty Care Resource Line, callers should dial **1-877-455-9955**.

Direct service providers and support coordinators should be certain to share this information with all of their waiver and EPSDT recipients.

USEFUL TELEPHONE NUMBERS AND WEBSITES FOR PROVIDERS

General Medicaid Eligibility Hotline	**Toll Free 1-888-342-6207**
Medicaid	**www.medicaid.dhh.louisiana.gov**
LaCHIP	**www.lachip.org**
LaCHIP Enrollee/Applicant Hotline	**Toll Free 1-877-252-2447**
MMIS/Claims Processing/Resolution Unit	**(225) 342-3855**
MMIS/Recipient Retroactive Reimbursement	**(225) 342-1739** **Toll Free 1-866-640-3905**
Medicare Saving Program (MSP) **Medicaid Purchase Hotline**	**1-888-544-7996**
KIDMED and CommunityCARE ACS	**1-800-259-4444**
For Hearing Impaired	**1-877-544-9544**
UNISYS-Provider Relations	**1-800-473-2783** **(225) 924-5040**
Pharmacy Hot Line	**1-800-437-9101**

Questions and Answers

CommunityCARE

1. Question:
Can a specialist who received a referral, refer the patient to another specialist?

Answer:
Depending on how the initial referral/authorization is written, it may be appropriate to "pass-on" or "share" a referral/authorization with another specialist. In fact, it is the responsibility of the specialist to "share" a copy of the PCP's initial written referral/authorization with labs/hospitals/radiologists, etc. for needed diagnostic services. It is also appropriate for one specialist to "pass-on" or "share" a copy of a referral/authorization when the services of another specialist is required for the further evaluation/treatment of the same condition covered by the PCP's initial written referral/authorization.

2. Question:
Does a hospital need a referral for outpatient services?

Answer:
Yes, with the exception of those services which are exempt from the referral requirement, including certain lab or x-ray services. Other exempt services are listed in the 2006 Provider Training packet

3. Question:
How does a provider ensure that the provider that issued the referral/authorization is the PCP of record on that date of service?

Answer:
Verify the recipient's eligibility! There are multiple ways to verify eligibility using e-MEVS, REVS and MEVS. Each of the eligibility verification systems provide the PCP's name and telephone number if the enrollee is linked to a PCP for that date of service.

4. Question:
How long do you have to go back and get a referral?

Answer:
Referrals/authorization for services rendered to a CommunityCARE enrollee, should be obtained **BEFORE** the service is rendered, with the exception of emergency room (ER) services. Patients should present for services everywhere except their Primary Care Providers (PCP) office with referral authorizations in their hand or already faxed before their arrival. PCPs should be the initiator of the referred to services, not the recipients. Post authorizations for emergency room services shall be requested the next business day.

CommunityCARE (continued)

5. Question:
What if a patient cannot get an appointment to see their PCP for several months?

Answer:
Policy states that for routine, non-urgent care a recipient should be seen within 20 days. If a PCP is not complying with the policy guidelines, it should be reported to the CommunityCARE Enrollee Hotline at **(800) 259-4444.**

6. Question:
Is the revised CommunityCARE referral/authorization form on the website?

Answer:
Yes. It is available on the CommunityCARE web site at www.la-CommunityCARE.com or the Louisiana Medicaid web site at www.lamedicaid.com.

Dental Providers

1. Question:
Can an oral surgeon bill the patient for anesthesia services not payable by Unisys?

Answer:
Nitrous oxide, intravenous conscious sedation/analgesia and non-intravenous conscious sedation are covered by Louisiana Medicaid with prior authorization when applicable. Medicaid-covered sedation should be offered to the patient, when appropriate, if it is provided in the dental office. If Medicaid-covered sedation is not provided in the dental office, the recipient must be informed prior to scheduling an appointment that the office does not provide Medicaid-covered sedation and that the recipient will be responsible for payment of anesthesia if such is required. This will allow the recipient to make an informed decision. Once the recipient is informed, he/she may be billed for services which have been identified as non-covered or exceeding a limitation set by the Medicaid Program.

2. Question:
Why are we getting 515 denials on root canals after we have received prior authorization?

Answer:
You should not receive a 515 denial on a root canal. The 515 denial is issued for certain 2nd restorations within a 12 month period. Medicaid policy does not reimburse for a 2nd restoration within a 12 month period unless the restoration is required due to pulpal necrosis or traumatic injury. Otherwise, the provider is responsible for the restoration for a period of 12 months. At this time, the claims that receive a 515 denial require a manual override in order to pay. Medicaid is in the process of developing a method to handle these claims for payment without requiring a manual override.

EPSDT Health Services Providers

1. Question:
Is CPT code 96101 a "per hour" or "per unit" charge?

Answer:
This is a "per unit" charge as only one unit of service (regardless of the amount of time spent for the psychological testing) is payable per day.

Hospice Providers

1. Question:
Can a Hospice provider bill for or accept a patient in an ICF-MR?

Answer:
Yes.

2. Question:
On hospice segments that require additional prior authorizations, can a nurse practitioner sign in place of a medical doctor?

Answer:
No; all periods, including those that require prior authorization, MUST be signed by a medical doctor. For the initial 90-day period both the patient's attending physician and the hospice medical director must sign. In the case of all periods following the initial 90-day period, the agency medical director's signature is acceptable.

3. Question:
When a patient has a private insurance as primary and Medicaid as secondary, does the same dual hospice and waiver service policy apply, whereby the patient must choose between hospice and waiver and cannot have both services at the same time?

Answer:
Yes.

4. Question:
Are there any exceptions to the policy whereby the signature of the certifying physician must be received on the CTI within 10-days in order to have the services covered? (Example: There are times when the patient elects hospice care, and their physician is on vacation and not available to sign the patient's forms.)

Answer:
No; in those types of cases, the physician covering for that doctor should sign the forms. The medical director should inform the staff how to handle the forms that require signatures in his/her absence.

Hospice Providers (continued)

5. Question:
How long does it take for a revocation of hospice service to get into the system?

Answer:
Generally 2 - 3 days, but additional time may be needed.

6. Question:
What should hospice providers do when they are unable to get hospitals to sign contracts to provide services to their patients?

Answer:
The State is aware of this situation and they are working with both hospitals and hospice providers to resolve the situation.

KIDMED Providers

1. Question:
How should the nurse practitioner bill interperiodic screenings?

Answer:
The nurse practitioner should use the age appropriate CPT code for interperiodic screenings in addition to using plus the TS modifier indicating interperiodic screening and TD modifier indicating nurse and submit on either a CMS 1500 claim form or electronically on 837P.

2. Question:
How do I adjust claims filed with the incorrect DOS?

Answer:
Information and instructions on adjustments/voids related to the KM-3 claim form can be found on page 28 of the *2006 Louisiana Medicaid KIDMED Provider Training* packet. Information and instructions on adjustments/voids related to the CMS 1500 Claim Form using the 213 Adjustment/Void form can be found on pages 53 and 54 of the *2006 Louisiana Medicaid KIDMED Provider Training* packet.

3. Question:
What if there are more than three (3) referrals on the KM-3 form?

Answer:
Please refer to the KM-3 Claim form completion instructions on page 23 of the *2006 Louisiana Medicaid KIDMED Provider Training* packet. The last paragraph of the explanation for blocks 33-35 indicates: "If there are more referrals than blocks 33-35 will accommodate, such referrals should be documented in the recipient's chart and would not be listed on the claim form."

KIDMED Providers (continued)

4. Question:
We often have difficulties finding specialists to refer the recipients to and keeping the referral within 60 days. What happens if it takes us more than 60 days to make an appointment for the child?

Answer:
Please refer to pages VIII -4 and 5 of *Louisiana KIDMED* manual revised April 1, 1994. The current telephone number is **1-800-259-4444** for Louisiana KIDMED (ACS) for assistance with finding Medicaid enrolled specialists and/or scheduling referrals. All referral efforts must be documented in the recipient's record.

5. Question:
On page 16 of the 2006 KIDMED Provider Training packet, Nursing Assessment /Evaluation, procedure code T1001 does not have 3 units listed. Has it changed?

Answer:
KIDMED nurse consult procedure code T1001 remains unchanged but documentation must be present in the recipient record justifying the medical necessity of the consult(s). See pages 16-17 of the *2006 Louisiana Medicaid KIDMED Provider Training* packet for detailed information on the use of KIDMED consultation codes. In part, this information states: "KIDMED consult codes are to be specific to an individual child's needs. Documentation should be present justifying the need for the consult for that particular child." Abuse of billing multiple units is subject to recoupment.

6. Question:
Will the CP-0-50 Returned Turnaround Documents (RTDs) ever be put in an electronic format?

Answer:
At this time there are no plans to have the CP-0-50 RTD reports available in an electronic format.

7. Question:
How do you know which combined vaccines are approved?

Answer:
Contact the Office of Public Health Vaccines for Children Program (VFC) at **(504)838-5300** for the most current VFC Order Form which indicates the approved VFC vaccines.

KIDMED Providers (continued)

8. Question:
If a new patient presents to a clinic and you cannot find proof that a PKU was done, do you have to find the record for the PKU to keep in the file?

Answer:
Only if the child is under 6 months of age or if it is medically indicated for children over 6 months. Refer to page 9 in *2006 KIDMED Provider Training* packet. You may also refer to page V-9 of the *Louisiana KIDMED* manual, April 1, 1994 for detailed information on PKU screening, including how to obtain results for initial screenings. The current telephone numbers for assistance with locating PKU and other neonatal screening results are the Office of Public Health, Central Laboratory at **(504) 219-4475** or Office of Public Health Genetics Disease Program **(504) 219-4413**.

9. Question:
When would a repeat PKU be required?

Answer:
Refer to *Louisiana KIDMED* manual, page V-9. In part, this information states: "You must re-screen an infant who was initially screened for PKU before 48 hours of age or if results are not available. The re-screening should be completed preferably between one and two weeks of age, but **no later than the third week of life**."

10. Question:
I always thought that a newborn screening performed in the hospital had 6 months to be filed instead of 60 days? Was the filing limit ever different for the newborn screening?

Answer:
All KIDMED screenings, regardless of setting, must be received within 60 days from date of service. See page 30 of the *2006 Louisiana Medicaid KIDMED Provider Training* packet.

11. Question:
Can we provide newborn screenings for a newborn that has not been assigned to a PCP?

Answer:
If you check eligibility, including KIDMED eligibility, and the child is not linked to a PCP for your date of service, you can provide and bill for the service. See page 5 of the *2006 Louisiana Medicaid KIDMED Provider Training* packet for information on verifying KIDMED linkages.

KIDMED Providers (continued)

12. Question:
Are we required to do a vision and hearing screening as part of the interperiodic screening for a sport physical, if the child is on schedule according to the periodicity schedule, and these screenings are not indicated for the age of the child? Also if we are required, is the reimbursement included in the interperiodic screening or should we bill for the screenings?

Answer: Vision and hearing screenings should be completed as part of an interperiodic screening for a sport physical if medically indicated as part of the sports physical. See the *Louisiana KIDMED* manual, pages VI-5 and VII-5.

Home and Community Based Services Waiver Providers

1. Question:
When an EDA Waiver participant is hospitalized, the direct service provider (DSP) can not provide services during the hospitalization. Can the DSP increase services after the participant returns home in order to use the approved units that were not provided during the hospitalization?

Answer:
No, the direct services provider cannot increase services when the recipient returns home from the hospital in order to bill for unused, approved service units that were not provided. When an EDA Waiver participant is hospitalized, the DSP cannot provide "Companion Service" in the hospital. If the participant's needs have changed significantly because of the hospitalization, the support coordinator can perform another assessment and submit all documentation to the Office of Aging and Adult Services (OAAS) regional office for further review.

EPSDT and Long-Term Personal Care Services Providers

1. Question:
From where are we to obtain the diagnosis for an EPSDT-PCS recipient?

Answer:
The diagnosis must be obtained from the recipient's physician.

2. Question:
When a Personal Care Services (PCS) recipient is hospitalized, the PCS provider cannot provide services during the hospitalization. Can the PCS provider increase services after the participant returns home in order to use the approved units that were not provided during the hospitalization?

EPSDT and Long-Term Personal Care Services Providers (continued)

Answer:
No. PCS units of service are approved for specific tasks. If the units are not used because the recipient was hospitalized, they may not be "banked" and used upon discharge. If the recipient's needs have changed, and additional units of service are needed upon discharge, a request must be made to address the need for additional units of service.

EPSDT-PCS requests must be submitted by the PCS provider to the Unisys Prior Authorization Unit.

LT-PCS requests for EDA waiver recipients must be made to the recipient's case manager. All other LT-PCS recipients must contact ACS to request an interim assessment to address additional units of service.

3. Question:
Why doesn't DHH allow an agency to provide LT-PCS in an adjacent region instead of an adjacent parish?

Answer:
The current policy requires that a provider agency maintain an office within the region(s) in which it serves. A provider agency is allowed to annex one parish outside of its service region without having to establish an additional office in that region.

4. Question:
Who should a provider contact if they suspect another provider is soliciting their clients?

Answer:
They need to contact the program manager for the LT-PCS Program at the following address:

Office of Aging and Adult Services (OAAS)
628 North 4th Street
Baton Rouge, LA 70821-0629
Attention: LT-PCS Program Manager
1-866-758-5035

5. Question:
Why are reimbursements for EPSDT-PCS different from LT-PCS?

Answer:
The EPSDT-PCS and LT-PCS Programs were implemented during different time periods and their respective reimbursement rate structures are representative of the prevailing trends at the time of program implementation.

EPSDT and Long-Term Personal Care Services Providers (continued)

6. Question:
We have been informed that LT-PCS assessments for additional service hours cannot be done for a year. Is this correct?

Answer:
No. Any time the recipient feels that their condition has changed, they may request a re-assessment. The decision to grant additional service hours will be based on medical necessity.

7. Question:
Assessors are not going to the recipient's home to conduct assessments. Old information is being used to base a decision for the request of additional hours where new information would be more relevant.

Answer:
It seems that there is some confusion about "assessments" and "interim assessments." Assessors go to the recipient's home to conduct an assessment or re-assessment; however, interim assessments may be conducted via telephone if certain criteria are met.

8. Question:
The number of hours allowed for LT-PCS services is being reduced when a recipient's condition has not changed. How can this be addressed?

Answer:
There are two circumstances that may cause a reduction in number of hours or service units when the recipient's condition has not changed.

The assignment of time for LT-PCS services is dependent not only on the medical condition of the recipient, but on the availability of natural, informal supports. If there are more supports available to a recipient whose condition has not changed, the service units for the recipient may be reduced.

If it is determined during a re-assessment or interim assessment that the number of service units previously approved for the recipient were incorrect, the service units for the recipient may be reduced. If the recipient disagrees with this decision, he/she may request an appeal through the Bureau of Appeals.

EPSDT and Long-Term Personal Care Services Providers (continued)

9. Question:
Relative to the safety of an elderly LT-PCS recipient, when can an LT-PCS employee leave the recipient if there is no family present and the employee has been told to go ahead and leave by a family member?

Answer:
The purpose of LT-PCS is to provide assistance with the specific tasks identified in the recipient's service plan. When these tasks have been completed for the day, the LT-PCS worker should leave as it is not required that he/she remain in the recipient's home until a family member arrives. Payment will not be made for any time that exceeds the prior authorized service units if the agency or their employees choose to remain with the recipient until a family member arrives.

10. Question:
Prior authorizations have been done for LT-PCS when the patient is not eligible for Medicaid; therefore, the provider is not aware of this until a denied claim is received. Why would this happen?

Answer:
It is important that the provider check the recipient's eligibility status on the **first day of each month**. This will eliminate the denial of claims for non-Medicaid eligibility. Please note that a recipient's eligibility status may change from the time a prior approval is granted and the time that services actually begin. It is the provider's responsibility to assure that the recipient has current Medicaid eligibility prior to the delivery of services.

11. Question:
Can a recipient's family member be reimbursed for providing LT-PCS?

Answer:
The LT-PCS Program prohibits Medicaid payments to a legally responsible relative to serve as the recipient's personal care service worker. Legally responsible relative is defined as the recipient's husband or wife, legal guardian, curator or tutor. A relative who is not legally responsible could be the recipient's LT-PCS worker if he/she meets the qualifications to be a PCS worker and is employed by a licensed, Medicaid-enrolled LT-PCS agency.

The mission of Medicaid funded personal care services is to supplement the family and/or community supports that are available to maintain the recipient in the community. It is <u>not</u> a substitute for available family and/or community supports.

EPSDT and Long Term Personal Care Services Providers (continued)

12. Question:
What should be done in the event a recipient seems to have no one to help them apply for LT-PCS?

Answer:
The recipient may choose a responsible representative (i.e. a friend, neighbor, or church member) to assist with the application process.

13. Question:
If LT-PCS prior authorizations are approved for a period of more than one year, any claims filed for a date of service over one year have denied. What should providers do to get the claim paid?

Answer:
Providers should contact the ACS Prior Authorization Department at **1-866-229-5222** for assistance.

Professional Services Providers

1. Question:
Does the CNS/CNP have to indicate the supervising physician's provider name or number in block 17 of the CMS 1500 Form?

Answer:
No, the supervising physician's provider name or ID number does not have to be entered in block 17 of the CMS-1500 Form for services rendered by a CNS or CNP.

2. Question:
Is a cardiologist limited to billing only modifiers listed in the Professional Training Packet?

Answer:
For recipients with Medicare and Medicaid, providers should submit the claim to Medicaid with the same modifiers used for Medicare. For recipients without Medicare coverage, only the modifiers listed on page 54 of the *2006 Professional Training Packet* are to be used. Modifier usage is not applicable to all CPT codes. Please refer to the most current CPT manual for codes exempt from modifier usage.

RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS

1. Question:
When KIDMED services are performed in the hospital, are they billed using the facility number and procedure codes?

Answer:
According to the Periodicity Schedule, a "newborn screening examination at birth must occur prior to hospital discharge." In this instance, age appropriate codes for the screening must be used. The services must be billed under the individual physician's ID number.

2. Question:
If a recipient over the age of 21 is seen by a nurse practitioner and is then referred to a physician on the same day, will both visits get paid?

Answer:
All encounters are billed with a T1015; therefore, only one visit will be paid if both a nurse practitioner and physician see a recipient (regardless of age) on the same date of service.

3. Question:
What should a provider do in the event a recipient's immunization records are missing?

Answer:
The provider needs to try to obtain this information through the LINKS database. If the immunizations have not been reported in the LINKS database, they may contact the local parish health unit. If the immunizations are a part of the health unit's database, a copy of the records can be given to the recipient/responsible party.

In the case of an infant, the parent/guardian should be questioned thoroughly and attempts should be made to obtain the immunization records from the health unit. If a child is in school, it is considered that their immunizations are current. If absolutely no immunization records can be obtained, then the immunizations need to be given/restarted as if the recipient had never previously received any immunizations.

4. Question:
If a dental procedure is not prior authorized due to non-medical necessity, yet the recipient wants to have the service can they pay for it themselves?

Answer:
Yes, however, the recipient can be charged ONLY the encounter rate. Be sure to document the recipient's records that he/she wishes to pay for these services.

RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS (continued)

5. Question:
If a recipient desires orthodontic services, can they go to an RHC/FQHC for these services instead of going to an orthodontist? Can the RHC/FQHC require/collect payment from the recipient?

Answer:
Orthodontic services performed at an RHC/FQHC are not reimbursable by Louisiana Medicaid. An orthodontist is not one of the licensed health care professionals who may generate an encounter. (Please refer to page 8 of the *2006 RHC/FQHC Training* packet for a list of those individuals who may generate an encounter.) If a recipient insists upon paying for the orthodontic service, they may do so. However, they should really be referred to an orthodontist who is a Medicaid provider.

6. Question:
Does a social worker have to be employed by the RHC/FQHC or can their services be contracted to the facility?

Answer:
It does not matter if the social worker is an employee or has a contract with the RHC/FQHC. Please note that the social worker's individual provider ID number must be linked to the provider ID number for the RHC/FQHC. Services rendered by social workers must be billable Medicaid covered services.

7. Question:
If a physician is signing a Plan of Care (POC), can he/she bill for this service?

Answer:
There has to be a face-to-face encounter between the physician and the recipient.

8. Question:
Can a RHC/FQHC bill if a physician speaks with a recipient's family about a possible nursing home admission for the recipient?

Answer:
No, there must be a face-to-face encounter between the physician and the recipient.

9. Question:
Which provider number (facility or individual number) should be used in the event of another hurricane disaster and recipients are in shelters?

Answer:
The facility ID number should be used in this circumstance.

RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS (continued)

10. Question:
If a recipient has four (4) other insurance carriers, where do you enter all four policy numbers on the CMS-1500?

Answer:
All Third Party Liability carrier codes must go in block 9A; however, it is very important to check eligibility with the other insurance carriers. If there is no coverage, you will need to file a claim to that particular carrier(s) in order to obtain documentation from the carrier verifying that there is no coverage for the recipient.

You then need to submit a cover letter, claim and **all** EOBs to:

DHH - Third Party Liability
Medicaid Recovery Unit
P. O. Box 91030,
Baton Rouge, LA, 70821

In your cover letter, be specific in asking DHH to update the recipient's file with the correct insurance information.

11. Question:
How can an FQHC know that a recipient has used all of their 15 allowable visits per calendar year? When eligibility is checked, information is reported only for 12 allowable visits.

Answer:
The provider can use the e-CDI web application and view the number of visits the recipient has incurred by clicking on the "Ancillary Services" and the "Physician/EPSDT Encounters" button and then counting to see how many visits have been paid. Be sure to count only the codes that apply to office/physician visits.

12. Question:
If we are rendering a KIDMED, Physician/Professional, or Dental service that is not covered by the respective program, can a RHC/FQHC bill for this service with the T1015?

Answer:
If you are rendering other services in addition to the non-covered service, you may indicate the non-covered service as one of the detail line items. If the only service that you are rendering is one that is truly non-payable under the KIDMED, Physician/Professional or Dental programs, the RHC/FQHC may not bill for these services. **At least one of the detail line items has to be a payable service.**

Web Applications

1. Question:
How often is the physician fee schedule updated?

Answer:
The fee schedule is updated monthly, and the current issue date can be found in the top left hand corner of the document.

2. Question:
How often is eligibility updated?

Answer:
The eligibility files are updated every night so current information is always available.

3. Question:
How can a provider find out who the administrator is on his/her provider number?

Answer:
You may call the Technical Support Unit at **1-877-598-8753**.

4. Question:
How many days does it take to get an approved PA when using the ePA application?

Answer:
There is not any set timeframe; as many factors affect the outcome of issuing a PA number through this application. While the time is significantly reduced by using ePA instead of hardcopy, it is still the provider's responsibility to ensure that the information is entered accurately and followed by a fax with all appropriate and required documentation.

5. Question:
When logging into the secure area with an individual provider number versus a group provider number will the applications display be different in the Provider Applications Area?

Answer:
Yes, the applications that are displayed for all providers upon logging into the Provider Applications Area depend upon the provider type of the logged in provider.

6. Question:
When will the e-RA be available to all providers to share referrals electronically?

Answer:
DHH and Unisys are working on the electronic application at this time and hopefully it will be available to the provider community soon.

Hospitals

1. Question:
Can providers still use Revenue Code 500 for some ER visits?

Answer:
No. ER visits for recipients that are later admitted should be billed on the inpatient claim using Revenue Code 450 or 459 and all associated revenue codes as appropriate.

2. Question:
Is there a separate way to bill DME charges when provided during an inpatient stay?

Answer:
The revenue code for supplies should be used to bill DME items provided during an inpatient stay.

3. Question:
Will a hospital receive additional payment for providing DME to patients during inpatient stays?

Answer:
For items such as Vagus Nerve Stimulator (VNS), cochlear implants and intrathecal baclofen therapy, additional payments are made (refer to the specific policies concerning these items). Other supplies are considered a part of the per diem reimbursement.

4. Question:
Is the completion of the form involved in Act 269 mandatory?

Answer:
The completion of the Act 269 form is mandatory. Effective June 15, 2005, the purpose of the Baby Bill, Act 269 was mandated to ensure reasonable requirements for the enrollment of newborns as dependents for health insurance coverage by health insurance issuers.

5. Question:
When does the use of revenue code 450 vs. 500 go into effect?

Answer:
The use of revenue code 500 as opposed to using revenue code 450 goes into effect immediately.

6. Question:
Can we bill the patient when the claim is denied for age restriction?

Answer:
First determine why the claim denied for age restriction. If you are using a diagnosis code that is age restricted, you need to find the appropriate diagnosis code for the recipient. If the procedure is age restricted and the service was medically necessary, DHH will consider an override of the age restriction based upon submitted documentation along with the override request.

Hospitals (continued)

7. Question:
Can we bill the patient when their benefits are exhausted on mammogram screening?

Answer:
Medicaid policy is specific on when a recipient can be billed. See page 5 of the Hospital Provider Training Manual for an explanation. As with other covered services with services limits, requests for exceptions may be submitted to DHH for review if the service is deemed medically necessary.

8. Question:
Is there a list of services that we can bill a patient for?

Answer:
No, there is not a list of services that can be billed to the recipient.

9. Question:
If there are codes not included on the 490 list, should we submit to DHH?

Answer:
No. This information is being collected from the denial codes as the providers file claims.

10. Question:
Can we bill the patient when the parent fails to terminate the other insurance at the parish office?

Answer:
No. You can send a copy of the TPL termination notice to DHH TPL unit. This unit will remove or add insurance information to the recipient's file.

11. Question:
Where more than one procedure is involved in the emergency room (ER) service, may we use more than one revenue code 450 or 459?

Answer:
No, you may not use more than one revenue code 450 or 459.

12. Question:
Do we have an updated list of Ambulatory Surgical Codes?

Answer:
Yes. Please check the NEW list located on the website at www.lamedicaid.com under Fee Schedules and the Hospital Outpatient Ambulatory Surgery Fee Schedule which is updated monthly.

Hospitals (continued)

13. Question:
Will there be a recycle of denied 490 codes?

Answer:
No. You should check the list to verify if the procedure has been added to the list and resubmit the claim once the procedure has been added to the list.

14. Question:
Are we required to bill associated revenue codes with 490 surgeries?

Answer:
Yes. All associated revenue codes for any charges associated with the surgery should be filed with the revenue code 490.

15. Question:
How does a hospital handle payments for car accidents when Medicaid is accepted and then the automobile insurance pays?

Answer:
Once a hospital accepts Medicaid as payment for an automobile accident, the claim cannot be voided later to accept a payment from a settlement or payment from car insurance or an attorney.

16. Question:
Does the amount of payment from the private insurance company that we place in block 54 include the payment and the contractual agreement or just the payment? If the correct way to bill this is to place the payment and the contractual agreement both in block 54, our payment is always zero even when all of the payment from the TPL goes to deductible. This doesn't seem fair. Can we bill the patient?

Answer:
The amount to be entered in form locator 54 on the UB92 is the amount the hospital has received toward payment of this bill from the private insurance carrier noted in form locator 50 B or C. If the patient has Medicare Part B only, enter the amount billed to Medicare. As a Medicaid provider, you have agreed to accept Medicaid reimbursement for services rendered as payment in full. The recipient cannot be billed for the difference.

17. Question:
Does Unisys have a cutoff time for sending the "old format" Electronic Remittance Advices to providers and having providers that receive this "old format" to move to the 835?

Answer:
Unisys does not have a cutoff time at this time for sending the "old format" Electronic Remittance Advices to providers.

Long Term Care Providers

1. Question:
Do you offer an electronic remittance advice?

Answer:
Prior to HIPAA implementation, providers received electronic remittance advices using Unisys proprietary specifications. Beginning with HIPAA implementation, electronic remittance advices are available through the 835 HIPAA complaint transactions.

2. Question:
Does the I-Cap rate apply to both private and state regulated facilities?

Answer:
No the I-Cap rate is only applicable to private ICF-MR facilities.

3. Question:
Is it possible to have batch processing for verification of eligibility?

Answer:
At this time, batch processing for eligibility is only offered through some MEVS vendors. You must contact the vendors to determine what they offer and the fee.

4. Question:
What is the correct billing procedure when the resident leaves the facility and the time frame between the 24 hour periods of the leave day/official state holiday is less than a full day?

Answer:
Official state holidays are excluded from the forty-five leave days for ICF-MR residents. Days before and after official state holidays would be counted as a leave day, if the individual is gone from the facility for 24 hours prior to the start of the official state holiday.

Example #1: A resident leaves the facility on Saturday, September 2 at noon and does not return to the facility until 8 a.m. on Tuesday, September 5th. The 24 hour period prior to the beginning of the leave day count ends at noon on Sunday, September 3rd. The period from noon until midnight on September 3rd is counted as a leave day. The period from midnight on September 4th - Labor Day, and the return on September 5th at 8 a.m. is not counted as a leave day.

Example #2: If a resident left the facility at 3:00 p.m. the day before an official declared holiday and did not return until noon the day after the officially declared state holiday, no leave day would be counted. There was no 24 hour continuous time away from the facility prior and/or after the official state holiday.

Long Term Care Providers (continued)

5. Question:
Are special event leave days to be reports on the plan of care? The training packets indicate the days are to be reported. Providers have been told through other avenues, some in writing, which days do not have to be reported on the plan of care. The facilities and or resident may not know at the time the plan of care is completed, if the resident is going to participate in a particular special event and this is the reason for the question.

Answer:
The plan of care is a working document. Additions can be made at anytime.

An Overview of Second-Generation Antihistamines

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Issues

- Antihistamines are effective in the treatment of symptoms associated with allergic rhinitis and urticaria.
- Second-generation antihistamines are preferred over first-generation antihistamines due to their improved adverse effect profile and convenience of use.

Introduction

Antihistamines are among the most widely used medications in the United States, especially when treating allergic rhinitis and urticaria. The first-generation antihistamines (Table 1) have been in existence and heavily used for years, but due to their unwanted adverse effects, a newer generation of antihistamines has been developed. The second-generation antihistamines (Table 1) are similar in efficacy to their predecessors, but have an improved adverse effect profile. The purpose of this paper is to give an overview of the second-generation antihistamines.

Clinical Pharmacology

Histamine (H1)-receptor antagonists exert their pharmacological effects by binding to H1 receptors and inactivating them. They are competitive antagonists in that they cause no action once bound to the receptor and also block histamine from binding. (13, 9) Competitive antagonism of the H1 receptor inhibits vasodilation, increased vascular permeability, itching, increased fluid exudation, and smooth muscle constriction associated with histamine release. (5, 14) In addition, H1-receptor antagonists have some anti-inflammatory properties; however, the mechanism of action for the anti-inflammatory activity is poorly understood. (7, 11)

First-generation H1-receptor antagonists do not have a high specificity for the H1 receptor as they also bind to and block muscarinic receptors causing anticholinergic effects. (8) The first-generation agents are highly lipophilic, which allows them to easily cross the blood-brain barrier where they occupy 50 to 90% of central H1-receptors, resulting in increased central nervous system adverse effects such as sedation. (11, 12) Newer, second-generation antihistamines are larger more lipophobic molecules, which makes it more difficult for them to cross the blood-brain barrier and occupy central H1-receptors. In general, these newer medications also have a much higher specificity for the H1-receptor.

Clinical Effects

Antihistamines are useful in treating a variety of disease states and symptoms. Because many of the first-generation antihistamines were marketed prior to the initiation of stringent controls for efficacy and safety, a paucity of well-controlled comparative studies exists demonstrating their efficacy in various disease states. Well-designed studies meeting current guidelines for evidence-based medicine have been completed evaluating the efficacy of second-generation

antihistamines in allergic rhinoconjunctivitis and chronic urticaria; however, few studies evaluate comparative efficacy among the second-generation agents. (12)

Antihistamines ameliorate or prevent many symptoms of allergic rhinoconjunctivitis such as sneezing, runny nose, red and watery eyes, and scratchy throat. In some cases, antihistamines may decrease nasal congestion associated with allergic rhinoconjunctivitis; however, in patients with significant nasal congestion as a symptom, the addition of an alpha1-antagonist to antihistaminic therapy is warranted. Many second-generation antihistamines have been approved by the Food and Drug Administration to treat seasonal allergic rhinitis (SAR) and perennial allergic rhinitis (PAR) (Table 2). SAR is primarily caused by seasonal outdoor allergens such as pollen, whereas PAR is more likely to be caused by indoor allergens such as dust mites and animals. (8) Antihistamines are more effective in preventing the allergic response than in ameliorating the response once allergen exposure and histamine release have occurred.

Therefore, in SAR, antihistamines provide more benefit if they are given before exposure to the antigen and used throughout the antigen season. (13) Allergic rhinitis is associated with increased patient morbidity and decreased quality of life, which may result in an increased number of missed days of school and work. Second-generation oral antihistamines are one of the first-line choices for the treatment of allergic rhinitis and its symptoms, and result in significant improvements in patient morbidity and quality of life. (8, 9)

Antihistamines are also used to relieve pruritis and decrease the number and size of wheals associated with urticaria. H1-receptor antagonists are the mainstay of treatment for urticaria. (11) There is a plethora of evidence confirming the effectiveness of cetirizine, desloratadine, fexofenadine, and loratadine in chronic urticaria. These agents are also used in the treatment of acute urticaria and atopic dermatitis despite a paucity of data supporting efficacy in these disorders. (12) These agents are most effective when given regularly versus on an as-needed basis for the treatment of chronic urticaria. (11) Both first- and second-generation H1-receptor antagonists have some efficacy in the treatment of urticaria; however, the significance and duration of the effect are dose-dependent. (13) Most studies indicate that second-generation antihistamines are now the preferred choice due to their improved adverse effect profiles. First-generation antihistamines may still be used as add-on therapy, and if used, are often dosed at bedtime. (9)

Antihistamines may also be used with epinephrine in the management of anaphylaxis. When given as adjunct therapy, antihistamines may decrease pruritis, rhinorrhea, edema, and urticaria associated with anaphylactic reactions. (12, 13) Occasionally, H1-receptor antagonists may be used as adjunct therapy treatment in asthmatics. They may reduce inflammation in the airways and prevent bronchospasm caused by histamine. (12, 13) Although little data exist to support their use, antihistamines may be effective as adjunct therapy in upper respiratory tract, ear, and sinus infections, especially when underlying allergic rhinitis is present. (12)

Pharmacokinetics

In general, antihistamines are well absorbed when administered orally, although some of them, such as chlorpheniramine and diphenhydramine, have a decreased bioavailability due to a large first-pass effect. (3) After one dose, the majority of H1-receptor antagonists begin to work within 1-3 hours and continue their action for 24 hours. (11) As a class, the antihistamines are highly protein-bound with the degree of binding ranging from 50-98%. (14) Even though first-generation antihistamines generally have longer half-lives than second-generation antihistamines, they are given in smaller doses several times a day due to their narrow therapeutic index. (3) This makes compliance with the second-generation medications much easier for patients.

All of the first-generation antihistamines, and some of the second-generation antihistamines, such as loratadine, are metabolized in the liver by the cytochrome P-450 system. Because of this route of metabolism, and the fact that antihistamines are often cleared renally, the dosages may need to be adjusted in patients with renal or hepatic dysfunction (see Table 3). (12, 8) Metabolism through the cytochrome P-450 system increases the potential for interactions with other medications, such as erythromycin and ketoconazole, and foods, such as grapefruit juice, that are metabolized the same way. Even though fexofenadine, cetirizine, and possibly desloratadine are not metabolized by the cytochrome P-450 system, there are other mechanisms that can cause the same type of drug-drug interactions. Coadministration of ketoconazole with fexofenadine or desloratadine greatly increases the drug plasma concentrations of these agents. Significant intake of grapefruit juice with concomitant administration of fexofenadine causes decreased plasma concentrations of fexofenadine. Decreased absorption of fexofenadine has also been reported when aluminum or magnesium antacids are given within 15 minutes of fexofenadine administration. (1) This interaction is of significant importance when counseling a patient due to the over-the-counter status of most antacids. Cetirizine is the only orally administered second-generation antihistamine that does not have an interaction with either ketoconazole or erythromycin. (8) However, theophylline decreases cetirizine's clearance. (15)

Desloratadine undergoes polymorphic metabolism with approximately 6% of the population being slow metabolizers with increased blood concentrations after a normal dose. The African-American population has a larger incidence of slow metabolizers (17%) compared to the Caucasian (2%) or Hispanic population (2%). Because slow metabolizers have decreased conversion of the parent drug to its metabolite, 3-hydroxydesloratadine, and may have higher concentrations of the parent compound, these patients may be at a higher risk for adverse effects, such as sedation. (8, 4)

Adverse Effects

The first-generation antihistamines have significant adverse effect profiles. Because of their ability to easily cross the blood-brain barrier, normal doses are associated with depression of the central nervous system resulting in drowsiness, sedation, decreased reaction time and impairment. (8,13) In fact, one of the most commonly used antihistamines, diphenhydramine, is often used in studies as an active control to demonstrate the nonsedating advantage of second-generation antihistamines. (11) Patients taking sedating antihistamines have a 1.5 times greater risk of being hurt while working, and in some driving tests, people taking diphenhydramine functioned worse than those with a blood alcohol level above the limit for legal impairment. (3, 12) Thirty-two states in the United States incorporated medications into their definitions of impaired driving, and drivers taking any of the first-generation antihistamines, and maybe even cetirizine, would be legally impaired by these standards. (3) The use of these sedating medications is contraindicated for airplane pilots, drivers, and anyone else in a position in which alertness is required. (12) Some think that tolerance to the sedating effects of antihistamines develops over time, but this has not been proven and does not always happen. (12, 3)

First-generation antihistamines also cause anticholinergic effects such as dry mouth, tachycardia, constipation, and urinary retention because of their blockade of muscarinic receptors. (8, 9) In particular, the drying effect caused by cholinergic antagonism of the first-generation antihistamines appears to be responsible for their efficacy in treating rhinorrhea caused by non-allergic mechanisms. In cases of overdose or drug-drug interactions, antihistamines, especially the first-generation antihistamines, have been shown to cause QT prolongation. (8) Other cardiac problems that rarely occur when taking antihistamines include arrhythmias, PTc prolongation and heart block. (13) After the removal of two second-generation antihistamines, terfenadine and astemizole, due to cardiotoxicity, first-generation antihistamines are now the most likely class of the antihistamines to cause cardiac adverse effects. (3)

The second-generation antihistamines were developed to have the same clinical efficacy as the first-generation antihistamines without the associated adverse effects. All first-generation antihistamines are more sedating than the second-generation medications. Of the second-generation antihistamines, cetirizine causes the most drowsiness, while fexofenadine's sedating properties are comparable to placebo, even at higher than recommended doses. (3, 8, 11) Loratadine and desloratadine do not display sedating characteristics at normal doses, but have displayed the capability of producing sedation at higher doses. Because of their lack of sedation, fexofenadine and loratadine have been approved by the United States Federal Aviation Administration for use in pilots. (3) The risk of cardiovascular adverse effects has been studied extensively in the second-generation antihistamines, and no cardiotoxicity has been found in patients using therapeutic and higher than recommended doses of cetirizine, loratadine, and fexofenadine; however, at a very high single dose of desloratadine, 45 mg, an increase in heart rate may occur. (9, 11)

Adverse effects associated with the second-generation antihistamines are minimal. One adverse effect of note is the bitter taste caused by the nasal application of azelastine. The only contraindication for these medications is hypersensitivity to the medication or any of its ingredients. (1, 2, 4, 15) In most patients, nonsedating, second-generation antihistamines are preferred over first-generation antihistamines, especially if they are at an increased risk for adverse effects, such as patients with CNS or heart disorders, renal or hepatic deficiency, low body weight, or the inclination to overuse medications. (3)

Special Populations

Antihistamines are first-line therapy for the treatment of allergic rhinitis in children. Ten percent of children and 20-30% of adolescents suffer from SAR, which can negatively affect their quality of life as well as their school work. When first-generation antihistamines are used, the sedation caused by these agents magnifies the negative effects of the condition itself and has been shown to further decrease learning performance in these children. (5, 10) Second-generation antihistamines have been proven effective and safe in the pediatric population. (9) Their approved indications (Table 2) and dosages (Table 3) are listed.

There are several reasons why the use of antihistamines in the elderly population is of concern and should be monitored. First of all, many elderly patients take a multitude of medications to treat different illnesses including allergic rhinitis. This places them at a higher risk to experience drug-drug interactions while taking antihistamines. Secondly, the pharmacokinetics of medications are often modified by advancing age. (5) For example, the average half-life of cetirizine is prolonged in the elderly. Additionally, after taking a single 80 mg dose of fexofenadine, the average Cmax is 68% higher and the half-life is 10.4% higher in patients over 65 years of age as compared to younger adult males. (14) The potential sedative effects of antihistamines is of particular concern in the elderly population as they are more sensitive to these effects and are also at a greater risk for falls. The anticholinergic effects of the first-generation antihistamines can complicate prostate problems in elderly men. (5) The sedative and anticholinergic effects are more commonly seen in first-generation antihistamines; therefore, second-generation antihistamines may be a better therapeutic choice for the elderly population.

When considering antihistamine therapy during pregnancy and breastfeeding, certain factors must be considered. Cetirizine and loratadine are both pregnancy category B, while fexofenadine, azelastine, and desloratadine are pregnancy category C. Category C medications should only be used in pregnant women when the potential benefit outweighs the potential risk to the fetus. (1, 2, 4, 15) Desloratadine, loratadine, and cetirizine are all excreted in breast milk; therefore, a decision should be made to discontinue either the medication or nursing. It is not known whether azelastine is excreted into breast milk and should therefore be used with caution in nursing mothers. (2, 15)

Conclusion

It is well known that the first-generation antihistamines are effective but have unwanted adverse effects. Due to their minimal adverse effect profile and comparable efficacy, the second-generation antihistamines have become the antihistamines of choice for the treatment of allergic rhinitis and urticaria. Health care providers can play a major role in the management of allergic rhinitis and urticaria by offering patients important information regarding prescription and OTC antihistamines. When selecting an antihistamine for a patient, there are many things to consider such as the patient's response and preference for a certain agent, route of administration, adverse effect profile, dosing schedule, and cost effectiveness. (9, 12)

Table 1. Classification of First and Second-generation Antihistamines

First-generation Antihistamines	Second-generation Antihistamines
Brompheniramine	Acrivastine (in combination with pseudoephedrine -- SemprexD®)
Chlorpheniramine	Azelastine (Astelin®-nasal) (Optivar®-ophthalmic)
Clemastine	Cetirizine (Zyrtec®)
Cyproheptadine	Desloratadine (Clarinex®)
Diphenhydramine	Fexofenadine (Allegra®)
Hydroxyzine	Loratadine (Claritin®)

Table 2. FDA Approved Indications for Second-generation Antihistamines

	Fexofenadine (Allegra®)	Azelastine (Astelin®)	Desloratidine (Clarinex®)	Loratidine (Claritin®)	Cetirizine (Zyrtec®)
Seasonal Allergic Rhinitis	6 years of age and older	5 years of age and older	2 years of age and older	2 years of age and older	2 years of age and older
Perennial Allergic Rhinitis	___	___	6 months of age and older	___	6 months of age and older
Vasomotor Rhinitis	___	12 years of age and older	___	___	___
Chronic Idiopathic Urticaria	6 years of age and older	___	6 months of age and older	2 years of age and older	6 months of age and older

Table 3. Usual Dosages and Dosage Adjustments for Second-generation Antihistamines						
Product	**Active Ingredient(s)**	**Available Strengths**	**Usual Dosage (Adults)**	**Usual Dosage (Children)**	**Renal/Hepatic Adjustment**	**OTC/ Rx**
Alavert®	Loratadine	10 mg	1 tab QD	Ages ≥6 yrs: Adult dose Ages <6 yrs: Ask a doctor	Yes/Yes	OTC
Alavert D-12 Hour®	Loratadine/ pseudoephedrine	5 mg/120 mg	1 tab BID	Ages ≥12 yrs: Adult dose Ages <12 yrs: Ask a doctor	Yes/Avoid	OTC
Allegra®	Fexofenadine	30 mg, 60 mg, 180 mg tab 60 mg cap	60 mg BID or 180 mg QD	Ages ≥12 yrs: Adult dose Ages 6-11 yrs: 30 mg BID	Yes/No	Rx
Allegra-D 12 Hour®	Fexofenadine/ pseudoephedrine	60 mg/120 mg	1 tab BID	Ages ≥12 yrs: Adult dose	Yes/No	Rx
Allegra-D 24 Hour®	Fexofenadine/ pseudoephedrine	180 mg/240 mg	1 tab QD	Ages ≥12 yrs: Adult dose	Avoid/No	Rx
Astelin®	Azelastine nasal spray	137 mcg per spray	2 sprays per nostril BID	Ages ≥12 yrs: Adult dose Ages 5-11 yrs: 1 spray per nostril BID	No/No	Rx
Claritin 24 Hour Allergy®, Claritin RediTabs®	Loratadine	10 mg	1 tab QD	Ages ≥6 yrs: Adult dose Ages <6 yrs: Ask a doctor	Yes/Yes	OTC
Claritin-D 12 Hour®	Loratadine/ pseudoephedrine	5 mg/120 mg	1 tab q12h	Ages ≥12 yrs: Adult dose Ages <12 yrs: Ask a doctor	Yes/Avoid	OTC
Claritin-D 24 Hour®	Loratadine/ pseudoephedrine	10 mg/240 mg	1 tab QD	Ages ≥12 yrs: Adult dose Ages <12 yrs: Ask a doctor	Yes/Avoid	OTC
Claritin Syrup®	Loratadine	1 mg/ml	2 tsp QD	Ages 2-6 yrs: 1 tsp QD Ages >6 yrs: 2 tsp QD	Yes/Yes	OTC

Clarinex®	Desloratadine	5 mg	1 tab QD	Ages ≥12 yrs: Adult dose	Yes/Yes	Rx
Clarinex RediTabs®	Desloratadine	2.5 mg, 5 mg	5mg tab QD	Ages ≥12 yrs: Adult dose Ages 6-11 yrs: 2.5mg tab QD	Yes/Yes	Rx
Clarinex Syrup®	Desloratadine	0.5 mg/1ml	2 tsp QD	Ages ≥12 yrs: Adult dose Ages 6-11 yrs: 1 tsp QD Ages 12mo-5 yrs: ½ tsp QD	Yes/Yes	Rx
Clarinex-D 12 Hour®	Desloratadine/ pseudoephedrine	2.5 mg/120 mg	1 tab BID	Ages ≥12 yrs: Adult dose	Avoid/Avoid	Rx
Clarinex-D 24 Hour®	Desloratadine/ pseudoephedrine	5 mg/240 mg	1 tab QD	Ages ≥12 yrs: Adult dose	Yes/Avoid	Rx
Optivar®	Azelastine ophthalmic solution	0.5 mg/1ml	1 gtt each eye BID	Ages ≥3 yrs: Adult dose	No/No	Rx
Semprex-D®	Acrivastine/ pseudoephedrine	8 mg/60 mg	1 tab q 4-6 h	Ages ≥12 yrs: Adult dose	Yes/No	Rx
Zyrtec®	Cetirizine	5 mg, 10 mg tabs and chewable tabs	5-10 mg QD (depending on symptom severity)	Ages ≥6 yrs: Adult dose	Yes/Yes	Rx
Zyrtec Syrup®	Cetirizine	1 mg/ml		Ages 2-5 yrs: ½-1 tsp QD Ages 6mo - <2yrs: ½ tsp QD; May increase to ½ tsp BID in ages 12-23 mos	Yes/Yes	Rx
Zyrtec-D 12 Hour®	Cetirizine/ pseudoephedrine	5 mg/120 mg	1 tab BID	Ages ≥12 yrs: Adult dose	Yes/Yes	Rx

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