Louisiana Medicaid

Provider Update

Volume 25, Issue 5 **September/October 2008**

Medication Attendant Certified

In July 2008, Louisiana began a three-year pilot program which establishes provisions for the use of the medication attendant certified (MAC) in licensed nursing facilities. The MAC is a certified nursing assistant (CNA), who has additional training in designated medication preparation and administration. The primary role of the MAC is to administer medications; therefore he/she should not have a patient care assignment that conflicts or distracts from this primary role. The medication attendant certified may only perform specific medication related duties and functions under the direct supervision of an on duty licensed nurse. The MAC's role is completely dependent upon delegation from a licensed nurse and he/she cannot function without this delegation.

Training and competency evaluation programs for MACs will be provided by the Louisiana Community and Technical College system. The core curriculum will be uniform throughout the state and will be a minimum of 100 hours in length with a minimum of 40 clinical hours.

Nursing facilities must apply to the Department to participate in training or to utilize medication attendants certified during the pilot program. The facility's compliance history will be reviewed as part of the application process, with special emphasis on noncompliance in the areas of medication administration. Applications for participation may be obtained from the DHH/Health Standards website at: http://www.dhh.louisiana.gov/offices/page.asp?id=112&detail=8553.

Table of Contents

Medication Attendant Certified (cont.)

A registry is being developed to identify all CNAs who have successfully completed the state-approved Medication Attendant Certified training and competency evaluation and criminal background check. MAC certification status will be indicated by an added field on the current CNA registry and will be maintained by the registry. The MAC certificate is valid for 12 months from the date of issue. To access the registry, log on to https://bhsfweb.dhh.louisiana.gov:444/tlcweb/frmSearch.aspx.

In order to evaluate the effectiveness of the MAC program and its impact on the quality of care in nursing facilities, educational programs and nursing facilities that choose to participate in the pilot program must participate in the evaluation of all components of the program. Evaluation forms designated by the Department must be submitted within the required time frames. Participating nursing facilities are also required to maintain documentation of medication errors on an ongoing basis and shall submit this information to the Department on a monthly basis. Medication error report forms may be obtained from the DHH/Health Standard website: http://www.dhh.louisiana.gov/offices/page.asp?id=112&detail=8553.

The rule containing the provisions governing medication attendants certified, published in the July 20, 2008 Louisiana Register may be accessed by logging on to the Office of the State Register's website at: http://www.doa.louisiana.gov/osr/reg/regs2008.htm.

Information on MAC registration status may be obtained by contacting Denise Traylor at 225-342-7715 or via e-mail at dtraylor@dhh.la.gov until the registry is fully operational.

Pediatric Moderate (Conscious) Sedation Update

Effective for date of service January 01, 2008, Louisiana Medicaid will reimburse for Current Procedural Terminology (CPT) procedure codes 99148, 99149, and 99150.

Louisiana Medicaid previously adopted CPT guidelines for procedures that include moderate sedation as an inherent part of providing the procedure (CPT Codes 99143-99145). Providers are now to follow CPT guidelines for all moderate sedation services currently listed in CPT (99143-99150).

Reimbursement will be made when a second physician provides the moderate sedation (CPT codes 99148-99150). In the unusual event a second physician, other than the health care professional performing the diagnostic or therapeutic services, provides moderate sedation in a facility setting (e.g., hospital, outpatient hospital/ambulatory surgery center, skilled nursing facility) for procedures listed in the CPT Appendix G, the second physician can report 99148, 99149, and /or 99150 as appropriate.

However, for the circumstances in which these services are performed by the second physician in a non-facility setting (e.g., physician office, freestanding imaging center), codes 99148-99150 should not be reported.

Medicaid payments received by providers for inappropriate services are subject to review, recoupment, and sanction.

**This update replaces the third bullet on page 21 of the published 2007 Professional Services Training.

Update on Optional State Supplement Payments and Check Write

Optional State Supplement (OSS) payments are now being processed on the **first working day of the month** and deposited via electronic funds transfer (EFT) in the providers' account within two or three days of that date.

Providers should remember that OSS funds are designated for the personal care needs of the resident and should be deposited in the resident's personal fund account within three business days of receipt of the EFT. Providers, who experience problems with their electronic funds transfer, may contact Provider Enrollment at (225) 216-6370 for assistance.

The Eligibility Support Section (ESS) of the Department of Health and Hospitals is now responsible for assisting providers with questions regarding OSS payments or refunds. Providers may contact the ESS office at (225) 342-3610.

Requests for Reconsideration

If a prior authorization (PA) request is not approved, a notification letter with the PA number is generated giving the reason(s) for the decision, and a copy of the notice is mailed to the provider, the recipient, and the support coordinator (if applicable). The provider may submit a reconsideration (RECON) request to the Unisys Prior Authorization Unit if they disagree with the decision.

To request a reconsideration, providers should submit the following information to the Unisys Prior Authorization Unit:

- A copy of the notice with RECON written across the top and the reason for requesting the reconsideration written across the bottom.
- All of the original documentation, as well as any additional information or documentation that supports medical necessity for the time that was not approved.

The Unisys physician consultant(s) will review the reconsideration request for medical necessity. After the review has been completed, another notification letter (with the same PA number) will be generated and mailed to the provider, the recipient, and the support coordinator (if applicable). As with all recipient notices, if service is not approved as requested, the recipient's notice will have information about his/her right to appeal.

Pediatric Otitis Media

Hilary Tice, Pharm.D., Assistant Professor, University of Louisiana at Monroe College of Pharmacy
Cain Doucet, Pharm.D. Candidate, University of Louisiana at Monroe College of Pharmacy
Sarah Neal, Pharm.D. Candidate, University of Louisiana at Monroe College of Pharmacy

Objectives:

- Define otitis media.
- Describe differences between acute otitis media (AOM) and otitis media with effusion (OME) with respect to pathophysiology, diagnosis, risk factors, treatment and cost.

The term otitis media refers to two separate but related diseases known as acute otitis media (AOM) and otitis media with effusion (OME). AOM is an infection of the middle-ear associated with acute onset of symptoms of middle-ear inflammation and middle-ear effusion (MEE).[1] OME in contrast is defined simply as the presence of fluid in the middle ear and is not associated with any signs or symptoms of acute ear infection.[2] Although the two are separate entities, AOM and OME are related in that both involve inflammation of the middle-ear and the acute infection seen in AOM is often followed by continued inflammation and effusion or OME. In addition, children with OME are more prone to recurrent AOM infections.

In the United States, AOM is the most common infection in children that results in the prescribing of antibiotics. This frequency of use impacts society from both direct and indirect costs. It is estimated that in 1995 the total cost of AOM was $2.98 billion and in 2000 it resulted in 16 million office visits and 13 million prescriptions.[1] While not as prevalent as its infectious counterpart the 2.2 million cases of OME annually cost an estimated $4.0 billion.[2]

The pathophysiology of both AOM and OME involves inflammation within and obstruction of the eustachian tube. Obstruction decreases air supply to the middle-ear mucosa leading to secretory metaplasia, compromise of the mucociliary transport system, and eventually the effusion of liquid into the tympanic cavity. It is debated whether infection can occur in the middle-ear in the absence of preexisting eustachian tube blockage; however, if infection begins without prior blockage, the edema and middle-ear secretions due to infection alone would lead to tubal blockage. The pathophysiology of OME does not involve infection of the middle-ear but is simply the result of a collection of fluid in the tympanic cavity and associated inflammation.[3] This collection of fluid may be a result of poor eustachian tube function alone or it may be the result of an inflammatory response in the time period following AOM infection.[2]

Table 1: Organisms commonly involved in otitis media

Organism[1,3]	**Prevalence**	**Antibiotic Resistance**
Streptococcus pneumoniae (most common)	20-50%	15-50% penicillin resistant (up to ½ with high level resistance)
Nontypable Haemophilus influenzae	15-30%	50% beta-lactamase +
Moraxella catarrhalis	3-20%	100% beta-lactamase +
Viral	40-75%	NA
Sterile	20-30%	NA
Other: *Staphylococcus aureus, S. pyogenes* & Gram-negative bacilli (*Pseudomonas aeruginosa*)		
Note: most episodes of AOM caused by *H. influenzae* and *M. catarrhalis* resolve spontaneously		

Modifiable and non-modifiable risk factors are defined within the 2004 guidelines for individuals between the ages of 2 months to 12 years.[1,2] Methods to alter modifiable risk factors include: the reduction of respiratory tract infections by reducing attendance of child care centers, breastfeeding for at least the first 6 months of life, avoiding supine bottle-feeding, reducing or eliminating pacifier use after 6 months of age, and eliminating exposure to tobacco smoke. All of these methods have been proposed as possible approaches to reduce the incidence of AOM; however, none have been definitively proven as effective.[1]

Diagnoses of AOM and OME differ in several ways. A key factor in differentiating the two is the onset of signs and symptoms. For a diagnosis of acute otitis media, one needs the following: *recent* and *abrupt* onset of signs and symptoms, the presence of middle-ear effusion (MEE), and signs or symptoms of middle-ear inflammation.[1] MEE is indicated by tympanic membrane bulging or fullness, limited or absent mobility of the tympanic membrane, air fluid level behind the tympanic membrane, or otorrhea. It is commonly confirmed by using pneumatic otoscopy. Other ways of confirming MEE include tympanocentesis and the presence of fluid in the external auditory canal due to perforation of the tympanic membrane. Signs or symptoms of middle-ear inflammation are indicated by distinct tympanic membrane erythema or distinct otalgia. Common findings such as otalgia, irritability, and fever are nonspecific and often overlap the findings associated with uncomplicated viral upper respiratory infection, making clinical history alone poorly predictive.[1] In order to diagnose AOM with certainty, visualization of the tympanic membrane with detection of MEE and inflammatory changes is required. Diagnosis of AOM may be complicated by the presence of a narrow ear canal, inability to maintain an adequate seal for successful pneumatic otoscopy or tympanometry, and not sufficiently clearing the external auditory ear canal of cerumen.[1] In OME, the tympanic membrane is often cloudy, has impaired mobility, and an air-fluid level or bubble is visible in the middle ear. Pneumatic otoscopy is also important in the diagnosis of OME as it has been shown to have the best balance of sensitivity and specificity.[2]

Due to the prevalence of these conditions, prevention should be encouraged by clinicians. AOM can be prevented by reducing risk factors and by providing influenza and pnuemococcal vaccines. Both killed and live-attenuated influenza vaccines have demonstrated more than 30% efficacy for prevention in children over 2 years of age.[1] Pneumococcal conjugate vaccines are effective in vaccine-serotype pneumococcal otitis media, but this benefit is small.[1]

When prevention does not work, treatment may be desired. Treatment of AOM should focus on both adjunctive therapy for pain, if present, and infection. Agents with proven efficacy in the treatment of pain in otitis media include acetaminophen and ibuprofen for mild to moderate pain and narcotic analgesia for moderate to severe pain. Alternative therapies that have been tried but lack clinical evidence to support their use include home remedies, topical agents, and homeopathic agents. Surgical interventions are usually reserved as a last line therapy due to their increased risk of complications.[1]

It should be noted that cost of treatment is a consideration for many patients. In a cost-effective analysis, it was found that the most effective strategy for AOM was 7 to 10 days of amoxicillin treatment while the least costly strategy was the delayed prescription or observation treatment.[4] Because antibiotic therapies can range from $10 to more than $100 for each individual course of treatment, it is important to determine if the recommended antibiotics for treatment of AOM provide the desired outcomes.[1] Efficacy and adherence are the two main contributors to favorable outcomes.[5] When determining treatment, a balance of effectiveness and tolerability is desired as these are the two main contributors to favorable outcomes.[5]

The American Academy of Pediatrics (AAP) guidelines published in 2004 incorporate utilization of an observation option. This option should be reserved for specific patients and consists of postponing antibiotics for 48 to 72 hours thus giving the condition time to resolve without treatment. Therapy in this case is limited to management of the symptoms involved. The patient's age, diagnostic certainty, and illness severity should be taken into account. A summary of the recommendations is located in the guidelines.[1] Assurance of follow-up is necessary for the purpose of antibiotic initiation if the symptoms of AOM worsen or persist.

If antibiotic therapy is chosen, first-line treatment should be based on the anticipated response to treatment and the suspected microbiological flora. Amoxicillin is generally used as first-line therapy due to its effectiveness against susceptible and intermediate resistant pneumococci, safety, low cost, acceptable taste, and narrow spectrum of activity. In patients who are suspected to have *H. influenzae* or *M. catarrhalis*, those with severe illness, or individuals who have failed therapy with amoxicillin, treatment should be initiated using high dose amoxicillin/potassium clavulanate. Certain children, such as those who attend daycare, have undergone antibiotic treatment within the past 30 days, or who are less than 2 years of age, are at a higher risk of being infected with bacteria that are resistant to amoxicillin alone. A summary of specific treatment strategies are defined in the 2004 guidelines while Table 2 on the following page summarizes dosing recommendations for the most commonly used agents.[1,2]

Table 2: Drug Therapy Overview

Drug	Indication	Dose	Route	Selected Side Effects	Other
Amoxicillin (Amoxil®, Trimox®)	Drug of choice initially and for resistant Streptococcus pneumoniae at high doses	80-90 mg/kg/day, divided every 12 hours	PO	Diarrhea, rash	Suspensions can be stored at room temp or refrigerated for 14 days, food does not alter efficacy; good taste and tolerability
Amoxicillin and Clavulanic acid (Augmentin®)	Recommended for patients who have severe AOM infections, require coverage for beta-lactamase + Haemophilus influenzae or Moraxella catarrhalis, or failed amoxicillin treatment	90 mg/kg/day (amox)/6.4 mg/kg/day (Clav), divided twice daily	PO	Diarrhea (especially from clavulanic acid component), rash	Suspensions should be refrigerated and discarded after 10 days; poor taste and tolerability
Azithromycin (Zithromax®)	Recommended alternative to amoxicillin for patients with type 1 allergies to penicillin	10 mg/kg/day once x 1 day then 5 mg/kg/day once daily x 4 days	IV/PO	Photosensitivity, rash, heart palpitations, chest pain, jaundice, CYP3A3/4 drug interactions	Suspensions can be stored at room temp or refrigerated for up to 10 days
Ceftriaxone (Rocephin®)	2nd line therapy, or for patients with severe course and PCN allergic	50 mg/kg (max 1 g) X 1 or 3 days (3 days in prior treatment failure)	IM/IV	Diarrhea, rash, prolonged therapy may cause hematologic, renal and hepatic alterations	Watch out for superinfections
Cefdinir (Omnicef®)	Recommended alternative to amoxicillin in NON type I PCN allergic patients	14 mg/kg/day once or twice daily	PO	Prolonged therapy may cause hematologic, renal and hepatic alterations, rash	Store at room temp up to 10 days, efficacy not affected by food, space iron/antacids 2 hours from drug administration
Cefuroxime (Ceftin®, Zinacef®)	Recommended alternative to amoxicillin in NON type I PCN allergic patients	Suspension: 30 mg/kg/day (max 1 gm/day) divided twice daily	IV/PO	Diarrhea, rash, prolonged therapy may cause hematologic, renal and hepatic alterations	Suspension can be stored at room temp or refrigerated for up to 10 days, food increases bioavailability; poor taste
Cefpodoxime (Vantin®)	Recommended alternative to amoxicillin in NON type I PCN allergic patients	10 mg/kg/day divided twice daily (max 800 mg/day)	PO	Diarrhea, rash, renal alterations with lengthy therapy	Store in refrigerator for up to 14 days, antacids & histamine H2 antagonists reduce bioavailability; poor taste
Clarithromycin (Biaxin®)	Recommended alternative to amoxicillin in type I PCN allergic patients	15 mg/kg/day divided twice daily	PO	Watch for drug interactions, diarrhea, rash	Store at room temp for up to 14 days, interacts with CYP3A3/4 & 1A2; metallic taste
Clindamycin (Cleocin®)	Documented PCN resistant Streptococcus pneumoniae, type I PCN allergic pt. with treatment failure	30-40 mg/kg/day divided three times daily	IV/PO	Diarrhea, rash, prolonged therapy may cause hematologic, renal and hepatic alterations	Store oral solution at room temp for up to 14 days; substrate for CYP3A3/4

Key: PCN = penicillin

Optimal duration of antibiotic therapy for AOM remains largely undefined. Length of therapy depends on age and severity of illness. For younger children (2-5 years of age) and those with severe illness, a 10-day course is considered optimal. For those ≥ 6 years of age with mild to moderate illness, a 5- to 7-day course is suitable. For all antibiotics, a clinical response is desired within 48 to 72 hours of starting therapy. During the first 24 hours, the patient may worsen slightly but most stabilize during this time period. In the second 24 hours, the patient should continue to improve. Fever should abate within 48 to 72 hours. All symptoms should improve and normalize; however, MEE may persist after acute symptoms have resolved. This is common and does not require active therapy. If no improvement is seen by 48 to 72 hours, therapy should be reevaluated. If AOM continues to persist, tympanocentesis should be performed to make a bacteriological diagnosis.

Antibiotics are not used for initial treatment of OME, instead, there is a 3 month period of watchful waiting, beginning with effusion onset, or from the date of diagnosis if the onset cannot be determined. For those children with OME who are at increased risk of developmental delays, management should include hearing assessment, speech and language evaluation and/or therapy, hearing aids, or tympanostomy tube insertion. Corticosteroids and antibiotics are not effective long-term so they are not recommended for routine management.[2] Other treatments that are used but not currently recommended for the treatment or control of OME include complementary and alternative therapy, allergy management, antihistamines, and decongestants.[6] Children who are not at risk for developmental delays, but have persistent OME, can be reexamined at 3- and 6-month intervals until the effusion resolves, significant hearing loss is identified, or the clinician suspects structural abnormalities of the middle ear or eardrum.[2]

If OME persists, the use of tympanostomy tubes is recommended. Removal of the adenoids is not recommended as initial therapy unless there is a distinct indication because it is more invasive and has added risks associated with the procedure. An adenoidectomy/myringotomy is recommended only if additional surgery is required after tympanostomy tube insertion. Neither a tonsillectomy nor myringotomy alone are recommended for treatment of OME.[2]

References

1. American Academy of Pediatrics. Subcommittee on Management of Acute Otitis Media. Diagnosis and management of acute otitis media. *Pediatr*. 2004;113(5):1451-65.

2. American Academy of Family Physicians, American Academy of Otolaryngology-Head and Neck Surgery and American Academy of Pediatrics Subcommittee on Otitis Media with Effusion. Otitis Media with Effusion. *Pediatr*. 2004;113:1412-1429.

3. Kerschner JE, Kliegman RM, eds. Otitis Media. *Nelson Textbook of Pediatrics, 18th ed* [book online]. Philadelphia, PA: Saunders Elsevier; 2007. http://www.mdconsult.com/das/book/body/101845445-2/0/1608/1502.html#4-u1.0-B978-1-4160-2450-7..50641-1--fn1. Accessed July 31, 2008.

4. Coco AS. Cost-effectiveness analysis of treatment options for acute otitis media. *Ann Fam Med*. 2007;5(1):29-38.

5. Pichichero ME, Brixner DI. A review of recommended antibiotic therapies with impact on outcomes in acute otitis media and acute bacterial sinusitis. *Am J Man* Care. 2006;12(10):S292-303.

6. Griffin GH, Flynn C, Bailey RE, Schultz JK. Antihistamines and/or decongestants for otitis media with effusion (OME) in children. *Cochrane Database of Systematic Reviews* 2006, Issue 4. Art. No.: CD003423. DOI: 10.1002/14651858.CD003423.pub2.

UNISYS

Provider Relations
P.O. Box 91024
Baton Rouge, LA 70821

PRSRT STD
U.S. POSTAGE PAID
BATON ROUGE, LA
PERMIT NO. 1037

FOR INFORMATION OR ASSISTANCE, CALL US!

Provider Enrollment	**(225) 216-6370**	**General Medicaid Eligibility Hotline**	**1-888-342-6207**
Prior Authorization			
Home Health/EPSDT - PCS	**1-800-807-1320**	**LaCHIP Enrollee/Applicant Hotline**	**1-877-252-2447**
Dental	**1-866-263-6534** **1-504-941-8206**		
DME & All Other	**1-800-488-6334** **(225) 928-5263**	**MMIS/Claims Processing/ Resolution Unit**	**(225) 342-3855**
Hospital Pre-Certification	**1-800-877-0666**	**MMIS/Recipient Retroactive Reimbursement**	**(225) 342-1739** **1-866-640-3905**
Provider Relations	**1-800-473-2783** **(225) 924-5040**	**Medicare Savings Program Medicaid Purchase Hotline**	**1-888-544-7996**
REVS Line	**1-800-776-6323** **(225) 216-REVS (7387)**	**KIDMED & CommunityCARE ACS**	**1-800-259-4444**
		For Hearing Impaired	**1-877-544-9544**
Point of Sale Help Desk	**1-800-648-0790** **(225) 216-6381**	**Pharmacy Hotline**	**1-800-437-9101**