Louisiana Medicaid

Provider Update

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Administration of H1N1 Vaccine

Providers administering the H1N1 influenza vaccine to Louisiana Medicaid recipients may submit claims for the administration of this vaccine to Medicaid. The American Medical Association (AMA) has released two new Current Procedural Terminology (CPT) codes, one specifically for the H1N1 vaccine (90663) and one for the administration of the H1N1 vaccine (90470). As the H1N1 vaccine is being supplied at no charge by the Office of Public Health (OPH) and to only those providers that previously registered with the OPH, Medicaid will reimburse providers for the administration only of the vaccine. Detailed policy and a fee schedule specific to the H1N1 influenza vaccine/administration are available on the Home page of www.lamedicaid.com. Providers should contact Unisys Provider Relations at (800) 473-2783 or (225) 924-5040 with billing or policy questions. Questions related to the H1N1 vaccine, including availability, should be directed to the OPH Immunization Program at (504) 838-5300.

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Direct Service Worker Registry

Health Standards, which is responsible for maintaining the Direct Service Worker (DSW) Registry for home and community-based services, reports delays in processing workers for placement on the DSW Registry. Approximately 50 percent of the forms that Health Standards receives from providers must be returned because the forms are either incomplete or have not been completed correctly. The Registry staff has identified the following as the most common errors:

- **The provider representative who signed the forms DSW 7, DSW 8 or DSW 9 is not on record as having authority to sign them for the provider.**

  Providers must ensure that all individuals who have been given the authority to sign off on forms DSW 7, DSW 8 or DSW 9 for their agency have signatures on file with the Registry staff.

- **Providers are failing to include verification of the 18-months of work history which occurred prior to 11/20/06 when submitting the form DSW 9 to "grandfather" a worker on to the Registry.**

  Providers must use a form DSW 7 to verify the 18-months of work history if the work was performed with their agency. If the work was performed with another agency, the current provider must submit verification of this employment history on agency letterhead. **Private duty or staffing agency employment will not count toward the 18-month work history requirement for the purpose of DSW registration.**

- **Providers fail to include form DSW 7 to document work history when submitting the forms DSW 8 or DSW 9.**

  The form DSW 7 is used to verify employment and must be included when submitting the forms DSW 8 or DSW 9. Workers will be removed from the Registry if there is no documentation of 40 hours of work in a 12-month period.

Health Standards encourages providers to periodically check the DSW Registry web site at www.labenfa.com to confirm the registration status of their direct service workers. Questions regarding the DSW registration process should be made to the Registry staff at (225) 295-8577.

Dental Providers

Dental Provider Reminders

Dental providers are reminded to update their files at least quarterly by logging on to www.lamedicaid.com under "Provider Login" to

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

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

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

Periodicity Schedule Update

Providers can view the Dental Periodicity Schedule by logging on to www.lamedicaid.com and clicking the "Billing Information" link and then the "Dental Billing Information" link. Providers are encouraged to follow this periodicity schedule.

Long Term Care Providers

Implementation of Denial Edits and Procedure Change for Patient Liability Adjustment Form

Effective November 1, 2009, the following denial edits will no longer be "educational edits" for nursing facility, intermediate care facility for persons with developmental disabilities and hospice claims with dates of service on or after October 1, 2009:

- **Error Code 159 - Long Term Care Provider Not Matched**
  This error code is generated when the provider submitting the claims is not the provider of record on the recipient eligibility file. When a recipient is certified for Medicaid long term care services, the provider number is entered into the eligibility system. The provider number on the billing document must agree with the provider number in the recipient eligibility file for the specific dates of service billed. The claim(s) will deny if this information does not match.

- **Error Code 173 - Level of Need/Level of Care Not Matched**
  This error code is generated when the billing document specifies a Level of Need Code that is not the same as the Level of Care Code. The claim(s) will pend for the first three billing cycles and then deny on the fourth cycle if no file correction can be made.

- **Error Code 525 - Level of Need/Level of Care Not on Recipient File**
  This error code is generated when the billing document includes a Level of Need/Level of Care Code that is not found on the Medicaid recipient file. The claim(s) will deny if this information does not match.

- **Error Code 568 - Not LTC Eligible**
  This error code is generated when the recipient has not been identified as eligible for LTC benefits. The claim(s) will deny if this information does not match.

Providers should contact their regional Medicaid representative or the regional Office for Citizens with Developmental Disabilities as appropriate for assistance in correcting the files. Providers should also make sure that the appropriate Revenue Code is used for the dates of service billed for each individual recipient. The Revenue Codes are used to determine the Level of Care/Level of Need and how the payment is calculated. The following table should be used as a guide for selecting the appropriate Revenue Codes:

	Revenue Code	Description
All Providers: Leave of Absence	183	Leave of Absence - Subcategory Therapeutic (for Home Leave)
	185	Leave of Absence - Subcategory Nursing Home (for Hospitalization)
Nursing Facilities: Level of Care	022	Skilled Nursing Facility Prospective Payment System (RUGS)/Case Mix (Formerly LOC 20, 21, 22)
	118	Room & Board - Private Sub-acute Rehabilitation/SNF, ICF I and ICF II
	193	Sub-acute Care Level III (Complex Care)/NF Complex Care
	194	Sub-acute Care Level IV/SNF Technology Dependent Care
	199	Other Sub-acute Care/SNF Infectious Disease
ICF/DDs: Level of Care	911	Psychiatric/Psychological Services - General/Public ICF/DD
	ICAP Revenue Codes to be used for dates of service on or after 10/1/05	
	193	Pervasive Level of Care (ICAP Score 1-19)
	192	Extensive Level of Care (ICAP Score 20-39)
	191	Limited Level of Care (ICAP Score 40-69)
	190	Intermittent Level of Care (ICAP Score 70-99)

Long Term Care Providers (Cont.)

Procedure Change for the Patient Liability Adjustment (148 PLI) Form

Effective November 1, 2009, all Patient Liability Adjustment (148 PLI) forms must be completed and submitted by a Bureau of Health Services Financing representative. **Providers may no longer complete and/or submit these forms for processing**. The 148 PLI Adjustment form is being revised to reflect these changes, and forms may no longer be obtained through Unisys. Providers should contact the recipient's Parish Medicaid Office if they have information or concerns about patient liability.

Long Term Care Facilities

Electronic Notification System for Long Term Care Facilities

The Department of Health and Hospitals (DHH) has developed an electronic submission process to enable long term care facilities to submit the Notification of Admission, Status Change, or Discharge for Facility Care (BHSF-Form 148), in order to improve the efficiency of providing Medicaid coverage to nursing facility residents. This process is expected to improve processing time associated with these changes by allowing the Medicaid Office, the Office of Aging and Adult Services (OAAS) and the Office for Citizens with Developmental Disabilities (OCDD) to retrieve requests simultaneously. Electronic submission of this form will not only reduce the costs associated with the printing of paper forms, it will also allow users to store and retrieve forms issued by the facility

The Facility Notification System can be accessed by logging on to either the:

- DHH website (www.medicaid.dhh.louisiana.gov) under Current Medicaid Providers, or
- Unisys website (www.lamedicaid.com) under the Forms Section

DHH provided training on the new Facility Notification System for facility representatives via webinar and teleconference. Additional information can be obtained by contacting the Medicaid Eligibility Systems Section by telephone at (225) 342-6398 or by e-mail at DHHProviderRequests@la.gov.

APPROPRIATE USE OF HYPNOTICS IN THE ELDERLY

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"Take a trional powder when you retire and you will not be troubled with insomnia." This is a too common advice given to the laity and patients when either time or lack of interest prevents a thorough examination for the cause of insomnia. Before falling into the rut of routine hypnotics, it is well to take more time to study every case of insomnia and ferret out the cause, remove it if possible, and little sleep-giving medicine will be needed.
- W. Blair Stewart, A.M., M.D. (JAMA 1904)1

Sleep disorders are commonplace in the elderly and can have a multitude of causes. Table 1 lists common causes of impaired sleep in the elderly. Insomnia, defined as the inability to commence or sustain sleep resulting in next-day consequences, is the most commonly reported sleep complaint in patients over the age of 60. This is manifested in roughly 40% of elderly patients being dissatisfied with their quality of sleep, with 25% showing signs of chronic insomnia. In addition, despite the substantial impact on the elderly population, and the negative effects on activities of daily living, less than 15% of these patients receive treatment.[2, 3]

Sleep has been described as an elaborate balance of variable stages that are subdivided into NREM (non-rapid eye movement) and REM (rapid eye movement) sleep. NREM consists of 4 progressively deepening stages of sleep. Stages 3 and 4 of NREM, or delta sleep, have been associated with the perception of sleep quality. Stage 5, or REM sleep, is distinguished by dreaming and is considered to be necessary for learning and temperament.[4]

There are a variety of sleep cycle alterations that occur in the elderly that can contribute to the development of insomnia. Older patients tend to spend more time in stages 1 and 2 of NREM sleep, while spending less time in delta sleep. Additionally, the elderly spend less time in REM sleep.[3] These changes may explain why the elderly report spending more time in bed yet less time sleeping. They also report waking more frequently during the night, taking longer naps, and having more issues with getting to sleep than younger people.[5]

The proper management of insomnia caused by situational, medical, or psychiatric causes should focus first on the alleviation of the primary disease state. However if a primary sleep disorder is expected, then a thorough clinical history and physical exam should be performed to properly establish diagnosis. Additionally, nocturnal polysomnographic recordings may be warranted to establish causality in previously difficult to treat cases of insomnia. Once the diagnosis of insomnia has been established, a variety of nonpharmacologic management techniques should be attempted prior to initiating drug therapy. Nondrug treatments have been well established and are often underutilized in the management of insomnia in the elderly. Table 2 lists potential nonpharmacologic treatments in the management of insomnia.[6]

Since elderly patients often see multiple practitioners for their care, it is important to evaluate polypharmacy as a potential root cause of insomnia. Therefore, subsequent to the use of nondrug treatments for insomnia, it is important for the practitioner to evaluate all current medications for their insomnia-causing potential. The classes of medications most commonly associated with insomnia include anticonvulsants, antidepressants, antihypertensives, decongestants, and pulmonary medications. If possible, all sedating medications should be given prior to bedtime, while stimulating medications and diuretics should be given earlier in the day. Table 3 lists medications commonly associated with insomnia.[3, 5]

Once a clinician has attempted nonpharmacologic treatments *and* the removal of insomnia-inducing medications without improvement in sleep quality or next-day consequences, then a sedative hypnotic would be indicated. These agents produce sedation and calming by depressing the central nervous system, which in turn leads to improvements in sleep latency and maintenance. The ideal agent would have a rapid onset to reduce sleep latency, prevent nocturnal awakenings, not alter sleep architecture, cause no daytime sedation, and would have little abuse potential. The current FDA-approved sedative hypnotic medications for insomnia are classified as benzodiazepines, nonbenzodiazepines, and a melatonin-receptor agonist.[4]

Benzodiazepines

There are currently five benzodiazepines approved by the FDA for the treatment of insomnia. They are flurazepam, quazepam, estazolam, temazepam, and triazolam. These drugs potentiate sedation by nonselectively binding various $GABA_A$-receptor subtypes. This in turn leads to decreased sleep latency, increased stage 2 sleep, slightly decreased delta and REM sleep, and increased total sleep time.[3, 4] Table 4 lists some characteristics of the FDA-approved benzodiazepines.

Although benzodiazepines as a group can decrease sleep latency, and improve total sleep time, most of these agents should be avoided in the elderly due to risks for complications. Both flurazepam and quazepam have long half-lives and produce active metabolites, which will lead to daytime sedation in the elderly. This led Dr. Mark Beers and colleagues in their 2002 update of "Inappropriate Medication Use in Older Adults" to give these medications a high severity rating, meaning that they should be avoided, due to their risk of sedation-induced falls and fractures.[7] Estazolam also is converted to a metabolite. However, this metabolite has minimal activity and therefore low potential for complications. The primary issue with estazolam, as with all the benzodiazepines discussed in this article except temazepam, is that it is metabolized via an oxidation reaction. As people age, the enzymes that mediate oxidation reactions become less abundant, leading to drug accumulation and the risk for greater daytime sedation. Triazolam would appear to be a good agent due to its quick onset and short half-life. However, this agent should also be avoided due to its risk of rebound insomnia and anterograde amnesia. Therefore, if the use of a benzodiazepine is the only option in this population, then temazepam may be a viable choice. It has an intermediate duration of action, avoiding the daytime sedation of the long-acting agents and the amnesia of the shorter-acting agents. Also, it is metabolized via a conjugation reaction meaning that its actions will be more predictable in the elderly. The bottom line is that benzodiazepines are only approved for short-term use (< 2 weeks), can cause respiratory suppression, have abuse potential, and can cause rebound insomnia with discontinuation. Therefore, the use of these agents should be limited or avoided in the elderly.

Nonbenzodiazepine Hypnotics

The nonbenzodiazepine compounds were originally developed to offer clinicians alternative therapies to benzodiazepines in the treatment of insomnia. Zolpidem, zaleplon, and eszopiclone also promote sleep through the GABA receptor, but differ from benzodiazepines in their selectivity for the alpha$_1$-subunit, leading to fewer adverse effects. Table 5 lists the FDA-approved nonbenzodiazepine hypnotics.

The characteristics that distinguish the nonbenzodiazepine hypnotics from one another are their onset, duration, and approval for chronic insomnia. Of these agents, zaleplon has the shortest onset (around 20 minutes) and the shortest duration of action (roughly 4 hours). This makes zaleplon an ideal agent in patients that have issues with sleep latency or in patients who cannot dedicate 8 hours to sleep after taking the agent. However, this may not be the best sleep maintenance medication because of its short duration of action, unless patients wait to take it until they wake in the middle of the night. Absorption of this agent can be slowed or decreased by a high fat meal so it is best for patients to take it on an empty stomach. Also, zaleplon is FDA approved for short-term use only. Zolpidem also has a quick onset and short duration of action, and is available in both standard and controlled release (CR) formulations. Therefore, the standard release formulation would be ideal in patients with sleep latency issues, while the CR formulation could be used in cases of combined sleep latency and maintenance insomnia. Additionally, the CR formulation is not limited to short-term use in the management of insomnia. Absorption of this agent can be slowed or decreased by food, so it is best for patients to take it on an empty stomach. It is important to note that abrupt discontinuation of this agent has been linked to withdrawal symptoms and 1st night rebound insomnia.[3, 4] Eszopiclone is an agent with an intermediate duration of action approved for the treatment of both sleep latency and maintenance. The recommended dosage in the elderly for sleep latency is 1mg, but for sleep maintenance is 2 mg. Absorption of this agent can be slowed or decreased by a high fat meal so it is best for patients to take it on an empty stomach. Although eszopiclone is approved for use in both short-term and chronic insomnia, the longest trials to date in the elderly were only for 2 weeks. Therefore the long-term effects of this agent in the elderly are unknown. [8, 9] Overall, the nonbenzodiazepine hypnotics have proven to be well tolerated in the elderly provided that the lowest effective doses are used for the least amount of time possible.

Melantonin-Receptor Agonist

Ramelteon is a highly selective melatonin receptor agonist approved for use in the treatment of insomnia characterized by difficulty falling asleep. It works by selectively targeting MT_1 and MT_2 receptors. These receptors are postulated to be key mediators in the maintenance of circadian rhythm, thus encouraging sleep. Table 6 lists the characteristics of ramelteon.

Ramelteon is approved for both short-term and chronic use in the treatment of insomnia. In clinical trials, it has shown no potential for abuse, which may explain why it is the only FDA approved hypnotic that is not a controlled substance. Additionally, it has been characterized as having a benign side effect profile and no hangover effects. Similar to the nonbenzodiazepines, the absorption of ramelteon can be decreased or delayed when taken with food. Overall, ramelteon appears to be well tolerated in the management of insomnia marked by difficulty falling asleep. However, there are no comparative trials at this time with other classes of agents.[10]

In conclusion, the management of insomnia in the elderly continues to be a great challenge. Often patients are quickly started, or continued, on potentially harmful medications without discerning the underlying cause of their sleeplessness. However, this can be overcome through a process of eliminating insomnia-causing medications, initiating nonpharmacological management strategies and, if necessary, choosing the safest most effective agent for the shortest duration of time possible.

Table 1
Causes of Insomnia in the Elderly

Situational	Medical	Psychiatric
Stress	**CV** (angina, arrhythmias, HF) **Respiratory** (COPD, sleep apnea) **Endocrine** (diabetes, hyperthyroidism) **GI** (GERD, PUD) **Neurological** (delirium, Parkinson's) **Urologic** (BPH) **Chronic pain**	**Depression** **Anxiety** **Substance abuse**

Adapted from reference 3

Table 2
Nonpharmacologic Treatments in the Management of Insomnia

Relaxation	Progressive muscle relaxation Autogenic training Pleasant imagery
Stimulus Control	Reserve bedroom for sleeping Only go to bed if sleepy Only sleep in the bedroom Get out of bed if awake and return only when sleepy Avoid daytime napping
Sleep Restriction	A 2 week sleep log is kept to determine average sleep time An allowed sleep time of > 5 hours is subjectively chosen The time allowed in bed is adjusted in 15 minute increments
Cognitive Behavioral Therapy (CBT)	Addresses the patient's perceptions of insomnia Attempts to break the "vicious-cycle" of insomnia
Sleep Hygiene	Avoid excessive amounts of caffeine Avoid eating late meals Avoid exercise late in the evening Maintain the same sleep schedule 7 days per week Do not watch television in bed Make sure that the bedroom is properly cooled and low lit
Light Therapy	Morning light exposure is used to resynchronize circadian rhythm

Adapted from reference 6

Table 3 Medications Commonly Associated with Insomnia	
Anticonvulsants	Phenytoin
Antidepressants	SSRIs Venlafaxine Nortriptyline
Antihypertensives	ß-blockers Diuretics
Decongestants	Pseudoephedrine
Pulmonary Medications	ß-agonists Corticosteroids Theophylline
Other	Alcohol Caffeine Cimetidine Nicotine Thyroid preparations
Adapted from references 3 and 5	

Table 4
Benzodiazepines FDA-Approved for Use in Insomnia

Drug	Elderly Daily Dose	Onset (mins)	$t_{1/2}$ (hrs)	Duration	Metabolic Pathway
Flurazepam (Dalmane®)	15 - 30 mg	60 - 120	47 - 100 (metabolites)	Long	Oxidation
Quazepam (Doral®)	7.5 mg	20 - 45	24 - 41 (metabolites)	Long	Oxidation
Estazolam (ProSom®)	0.5 - 1 mg	15 - 30	8 - 24 (metabolites)	Intermediate	Oxidation
Temazepam (Restoril®)	7.5 - 15 mg	45 - 60	10 - 20	Intermediate	Conjugation
Triazolam (Halcion®)	0.125 mg	15 - 30	1.6 - 5.4	Short	Oxidation

Adapted from references 3 and 4

Table 5
Nonbenzodiazepines FDA Approved For Use In Insomnia

Drug	Elderly Dose	Onset (mins)	$t_{1/2}$ (hrs)	Duration	Common Side Effects
Zaleplon (Sonata®)	5 mg	20	0.5 - 1	Very short	Headache, dizziness
Zolpidem (Ambien®, Ambien CR®)	5mg 6.25mg (CR)	30	2.5 2.8 (CR)	Short	Residual drowsiness, dizziness, diarrhea, headache
Eszopiclone (Lunesta®)	1 - 2 mg	30	6	Intermediate	Unpleasant taste, headache, dizziness

Adapted from references 3, 4, and 8

Table 6
Melatonin-receptor agonist FDA Approved For Use In Insomnia

Drug	Elderly Dose	Onset (mins)	$t_{1/2}$ (hrs)	Duration	Common side effects
Ramelteon (Rozerem®)	8 mg	30	1 - 2.6	Short	Headache, somnolence, dizziness

Adapted from references 4 and 10

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