Louisiana Medicaid

Provider Update

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OVERWEIGHT KIDS GETTING GROWNUP DISEASES

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The nation's childhood obesity problem is hitting pediatricians' offices as children, aging before their time; show up with conditions more common in middle-aged adults.

In Atlanta, as across the country, doctors are seeing young patients with Type 2 diabetes, gallstones, and even nonalcoholic cirrhosis that can require a liver transplant.

Although the overall numbers of cases are small, the nation's physicians are expressing concern that rising obesity in children has grave implications for the future. As children put on additional pounds, their rates of diseases are likely to increase, shortening lives and expanding demand for health care.

"Childhood obesity is not just a cosmetic problem," said Dr. William Cochran, who specializes in treating overweight children and adolescents at the Geisinger Clinic in Danville, Pa. "It's a serious health problem facing our entire society."

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The occurrence of adult diseases in obese children has been the subject of much discussion in the medical community lately. It was discussed at an American Academy of Pediatrics meeting in Atlanta this month and has been the topic of articles in recent medical journals.

Fatty liver disease, a key cause of cirrhosis, was not even recognized in children until the mid-1990s, said Dr. Miriam Vos, a pediatric hepatologist at Emory University School of Medicine. Now, she said, it's the most common liver disease in children. Such diseases are just the latest result of a steep rise of obesity among children over the last two decades. According to the National Center for Health Statistics, about 34 percent of U.S. children ages 6-19 are overweight. About half of those or 17 percent are considered obese, up from 11 percent in 1994. Meanwhile, an estimated 66 percent of American adults are obese or overweight, compared to 56 percent a dozen years ago.

Health statisticians base the ratings on the body mass index, or weight-to-height ratio, adjusted for gender.

Rates are highest among African-American and Hispanic adolescents. Statistics from 2002 showed that almost 24 percent of black girls 12-19 and almost 19 percent of black boys in the same age group were obese. Likewise, almost 20 percent of Mexican-American teenage girls and 15 percent of boys were obese. Poverty is a key factor, experts say. About 20 percent of children and adolescents below the poverty level were considered obese.

Research shows and doctors are seeing that overweight children, like overweight adults, have more hypertension, breathing disorders, sleep problems and bone-and-joint complications than their thinner counterparts. Long term, they are at greater risk of developing heart disease and some forms of cancer.

But researchers are only beginning to realize the full effects of severe obesity in children. Often conditions intertwine and overlap. Uncontrolled diabetes, for instance, is linked to fatty liver disease.

Type 2 diabetes, formerly referred to as adult-onset, now represents up to 45 percent of new diagnoses of diabetes in children and adolescents, according to surveys reported in pediatric journals. Unlike so-called juvenile diabetes, or Type 1, it is linked to weight.

"This has been developing insidiously," said Alice Smith, who manages a diabetes prevention program as part of her duties at Children's Healthcare of Atlanta. "It tracks along with the increase in prevalence of obesity over the last 15 to 20 years."

Uncontrolled diabetes can result in amputation of limbs, blindness and kidney disease. It is aggravated by heavy consumption of fats and sugars, which can also tax the liver and cause damage, eventually possibly leading to cirrhosis.

In a study published this month, researchers at the University of California, San Diego, found that 38 percent of obese children among a group of 742 accident victims had fatty livers, a problem that for many would have developed into a serious health threat.

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Five percent to 10 percent of adults with fatty livers eventually develop cirrhosis and may need transplants, said Vos, who specializes in fatty liver disease in children at Children's Healthcare of Atlanta. Although cirrhosis is still uncommon in children, some teenagers have already had transplants as a result of obesity-related cirrhosis; others are awaiting transplants, Vos said.

"If you say a third of obese children have liver disease, and 10 percent of them will end up with cirrhosis, that is a very frightening number," she said.

Dr. Mark Wulkan, a pediatric surgeon at Emory Medical School and Children's Healthcare, sees the consequence of obesity in children's gallbladders, the pear-shaped organs that store bile. Surgeons, he said, used to talk about the "three F's of gallbladder disease - fat, forty and fertile," meaning most patients were middle-aged women. Now, Wulkan said, it's showing up in adolescents, and "occasionally even in younger kids."

Eight years ago when Wulkan started work at Egleston, the seven pediatric surgeons removed a child's gallbladder because of gallstones every couple of months. Now, he said, the rate is more like every couple of weeks. Gallstones deposits of cholesterol or calcium salts in the gallbladder or nearby bile ducts are often symptom less. If they cause pain, or if the gallbladder becomes swollen or infected, it should be removed, said Wulkan.

Some children get gallstones as a result of other medical conditions, such as sickle-cell anemia. But Wulkan said pediatric gastroenterologists are seeing more gallstones. "It's clearly related to weight," he said. One of the few recent studies that attempt to quantify the increase of gallbladder disease in children came from Germany this year. Scientists at the University of Elm looked at 493 obese children and adolescents 8-19 years old. They found gallstones in 10 or about 2 percent all of whom had been through puberty. Eight were girls.

Physicians dealing with obese children who have these formerly adult conditions say the complications are likely to become even more common if the country doesn't do better by its children's nutrition. "It has to be a multifaceted approach," said Cochran of the Geisinger Clinic, who spoke at the American Academy of Pediatrics in Atlanta earlier this month. "Children, families, schools, communities, health care providers, insurance companies, the government. No one institution can solve this problem."

2006 Health Care in America Survey

The Henry J. Kaiser Family Foundation, USA Today, and ABC News conducted a survey of 1,201 adults over the age of 18 on the state of health care in America. The survey, which was conducted from September 7th to 12th, 2006 focused on the respondents' opinions related to health care costs and quality. In October, the Kaiser Foundation released the results of that survey. The following is a summary of the results.

The results revealed that most Americans are dissatisfied with the nation's health care system. The primary source of dissatisfaction is the costs of health care. An overwhelming 80% of respondents were concerned with the costs; while 54% were not satisfied with the quality of care. However, there is a caveat to these findings. Most of those surveyed (88%) rated their coverage as good or excellent. Despite this finding, health care costs remained a big concern, with 6 of 10 respondents expressing concern regarding the affordability of the premiums.

Concerns that Focus on Costs, Coverage, and Payment

Approximately 25% of those surveyed reported that they or someone in their family had problems paying for medical bills in the past year. This figure jumps to 40% for young people (ages 18-29), 42% for those making less than $35,000 a year, and 59% for the uninsured.

Twenty-eight percent (28%) report that someone in their family delayed care in the past year. Most respondents reported that condition requiring treatment was somewhat serious (70%). This figure reflects a large increase from previous ABC and Gallup polls
(14 and 25% from 1991-2003). 68 % of the uninsured had delayed care during the same period. The majority of those reporting difficulties paying for care (69%) had health insurance.

The cost of insurance was a major barrier for those who do not currently have coverage (54%). Another 15% have been refused coverage due to poor health. Only 4% indicated that they did not need it.

Cost Does not Equal Quality

Seventy-six percent (76%) of those surveyed agreed that doctors who charge higher prices do not necessarily provide better care. However when it comes to drugs and treatment, respondents were more divided. 47% felt that new expensive drugs and treatments were more effective than less expensive alternatives; while 43% felt the tried and true were just as effective.

Controlling Costs

Sixty-two percent (62%) of those surveyed say that insurance companies should not have to pay for expensive new treatments unless they have been proven more effective than the existing ones, even if a doctor specifically recommends them. 79% say that allowing people to shop for their health care would be more effective at controlling costs than the current system of employer based coverage or government regulations.

Two in three (66%) are opposed to plans that would only cover major medical problems with the consumer handling other medical needs that comes out of a pool of money that he/she has control.

Who Is at Fault

Several reasons have been cited for public dissatisfaction with health care cost. These reasons include:

Excessive profits earned by drug companies.....50%
Fraud and waste in the health care system.....37%
High profits received by doctors.....36%
Too many malpractice suits.....37%

Patients were the least blamed for the rising costs: 30% blamed unnecessary treatment

Unhealthy lifestyles blamed as contributing factors.....29%
New drugs and technology.....28%
An aging population.....23% and
More people getting better care.....2 %

Interest in Change is Dampened by Real Trade Offs

The plight of the uninsured remains an area of concern for the majority of Americans. 52% of the respondent state that 46 million people lacking health insurance is a critical problem. 68% say that providing health insurance is more important than keeping taxes down. However, if the focus is on rising health care costs, respondents were more divided: 50% say reducing costs is more important, while 42% say extending coverage should be the focus.

There was strong support (56%) for universal health care until the downside of such a plan is explained. The negatives aspect include, less choice of providers, waiting lists, increased costs to individuals, or more limited coverage.

The supports for universal health care dropped by one-third, after these negatives aspects were explored. However, only 50% anticipated a change in their own personal health care in terms of quality, availability and choice. Of those that supported this concept, only 34% anticipated improvement in their own health care costs. Of those who anticipate a difference in quality, twice as many see it as negative rather than positive.

A majority of respondents would support a variety of other government efforts to expand health care coverage. Sixty-nine percent (69%) favor requiring employers to cover full time employees, 61% stated that tax breaks should be offered to businesses that offer health insurance to their employees, and 55% favor expanding existing government programs such as Medicare and Medicaid.

The entire survey can be found at the Kaiser Family Foundation website: http://www.kff.org/kaiser-polls/pomr101606pkg.cfm

The following notices regarding special Medicaid benefits for children and youth are being republished as a reminder to providers of the services available to Medicaid recipients up to the age of twenty-one (21).

SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

THE FOLLOWING SERVICES ARE AVAILABLE TO CHILDREN AND YOUTH WITH DEVELOPMENTAL DISABILITIES. TO REQUEST SERVICES YOU MAY CALL THE OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD) OR DISTRICT AUTHORITY IN YOUR AREA.

(See listing of numbers on attachment)

MR/DD MEDICAID WAIVER SERVICES

To sign up for "waiver programs" that offer Medicaid and additional services to eligible persons (including those whose income may be too high for other Medicaid), ask to be added to the Mentally Retarded/ Developmentally Disabled (MR/DD) Request for Services Registry (RFSR). The **New Opportunities Waiver (NOW)** and the **Children's Choice Waiver** both provide services in the home, instead of in an institution, to persons who have mental retardation and/or other developmental disabilities. Both waivers cover Family Support, Center-Based Respite, Environmental Accessibility Modifications, and Specialized Medical Equipment and Supplies. In addition, **NOW** covers services to help individuals live alone in the community or to assist with employment, and professional and nursing services beyond those that Medicaid usually covers. The **Children's Choice Waiver** also includes Family Training. Children remain eligible for the Children's Choice Waiver until their nineteenth birthday, at which time they will be transferred to an appropriate Mentally Retarded/Developmentally Disabled (MR/DD) Waiver.

(If you are accessing services for someone 0-3, please contact EarlySteps at 1-866-327-5978.)

SUPPORT COORDINATION

A support coordinator works with you to develop a comprehensive list of all needed services (such as medical care, therapies, personal care services, equipment, social services, and educational services) then assists you in obtaining them. If you are a Medicaid recipient and under the age of 21 and it is medically necessary, you may be eligible to receive support coordination services immediately.

THE FOLLOWING BENEFITS ARE AVAILABLE TO ALL MEDICAID ELIGIBLE CHILDREN AND YOUTH UNDER THE AGE OF 21 WHO HAVE A MEDICAL NEED TO ACCESS THESE SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544)

MENTAL HEALTH REHABILITATION SERVICES

Medicaid participants under age 21 with mental illness or emotional/behavioral disorders who meet the program's medical necessity criteria may receive Mental Health Rehabilitation Services (MHR). These services include: assessment, reassessment medication management, individual and group counseling, community support services, parent/family counseling, parent/family intensive intervention and group psychosocial skills training. Services are accessed by contacting a MHR provider agency. No Primary Care Provider referral is required. The mental health prior authorization unit must pre-approve all Mental Health Rehabilitation services. **Note: Recipients ages 18 to 21 are initially screened as adults. If they are determined ineligible under adult criteria, they must be reassessed using the children's medical necessity criteria.**

PSYCHOLOGICAL AND BEHAVIORAL SERVICES

Children and youth who require psychological and/or behavioral services may receive these services from a licensed psychologist. These services include necessary assessments and evaluations, individual therapy, and family therapy.

EPSDT/KIDMED EXAMS AND CHECKUPS

Medicaid recipients under the age of 21 are eligible for checkups ("EPSDT screens"). These checkups include a health history; physical exam; immunizations; laboratory tests, including lead blood level assessment; vision and hearing checks; and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed. EPSDT screens may help to find problems, which need other health treatment or additional services. **Children under 21 are entitled to receive all medically necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. This includes a wide range of services not covered by Medicaid for recipients over the age of 21.**

PERSONAL CARE SERVICES

Personal Care Services (PCS) are provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing, and personal hygiene. PCS services do not include medical tasks such as medication administration, tracheotomy care, feeding tubes or catheters. The Medicaid *Home Health* program or *Extended Home Health* program covers those medical services. PCS services must be ordered by a physician. The PCS service provider must request approval for the service from Medicaid.

EXTENDED SKILLED NURSING SERVICES

Children and youth may be eligible to receive Skilled Nursing Services in the home. These services are provided by a Home Health Agency. A physician must order this service. Once ordered by a physician, the home health agency must request approval for the service from Medicaid.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, AUDIOLOGY SERVICES, and PSYCHOLOGICAL EVALUATION AND TREATMENT

If a child or youth wants rehabilitation services such as Physical, Occupational, or Speech Therapy, Audiology Services, or Psychological Evaluation and Treatment; these services can be provided at school, in an early intervention center, in an outpatient facility, in a rehabilitation center, at home, or in a combination of settings, depending on the child's needs. For Medicaid to cover these services at school (ages 3 to 21), or early intervention centers and EarlySteps (ages 0 to 3), they must be part of the Individualized Education Plan (IEP) or Individualized Family Services Plan (IFSP). For Medicaid to cover the services through an outpatient facility, rehabilitation center, or home health, they must be ordered by a physician and be prior-authorized by Medicaid.

FOR INFORMATION ON RECEIVING THESE THERAPIES, CONTACT YOUR SCHOOL OR EARLY INTERVENTION CENTER. EARLYSTEPS CAN BE CONTACTED Toll Free AT 1-866-327-5978 or CALL KIDMED REFERRAL ASSISTANCE AT 1-877-455-9955 TO LOCATE OTHER THERAPY PROVIDERS.

MEDICAL EQUIPMENT AND SUPPLIES

Children and youth can obtain any medically necessary medical supplies, equipment and appliances needed to correct, or improve physical or mental conditions. Medical equipment and supplies must be ordered by a physician. Once ordered by a physician, the supplier of the equipment or supplies must request approval for them from Medicaid.

TRANSPORTATION

Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours in advance. Children under age 21 are entitled to receive all medically necessary health care, diagnostic services, treatment, and other measures that Medicaid can cover. This includes many services that are not covered for adults.

IF YOU NEED A SERVICE THAT IS NOT LISTED ABOVE CALL THE REFERRAL ASSISTANCE COORDINATOR AT KIDMED (TOLL FREE) 1-877-455- 9955 (OR TTY 1-877-544-9544). IF THEY CANNOT REFER YOU TO A PROVIDER OF THE SERVICE YOU NEED, CALL 1-888-758-2220 FOR ASSISTANCE.

Services Available to Medicaid Eligible Children Under 21

If you are a Medicaid recipient under the age of 21, you may be eligible for the following services:

*Doctor's Visits
*Hospital (inpatient and outpatient) Services
*Lab and X-ray Tests
*Family Planning
*Home Health Care
*Dental Care
*Rehabilitation Services
*Prescription Drugs
*Medical Equipment, Appliances and Supplies (DME)
*Case Management
*Speech and Language Evaluations and Therapies
*Occupational Therapy
*Physical Therapy
*Psychological Evaluations and Therapy
*Psychological and Behavior Services
*Podiatry Services
*Optometrist Services
*Hospice Services
*Extended Skilled Nurse Services
*Residential Institutional Care or Home and Community Based (Waiver) Services
*Medical, Dental, Vision and Hearing Screenings, both Periodic and Interperiodic
*Immunizations
*Eyeglasses
*Hearing Aids
*Psychiatric Hospital Care
*Personal Care Services
*Audiological Services
*Necessary Transportation: Ambulance Transportation, Non-ambulance Transportation
*Appointment Scheduling Assistance
*Substance Abuse Clinic Services
*Chiropractic Services
*Prenatal Care
*Certified Nurse Midwives
*Certified Nurse Practitioners
*Mental Health Rehabilitation
*Mental Health Clinic Services

and any other medically necessary health care, diagnostic services, treatment, and other measures which are coverable by Medicaid, which includes a wide range of services not covered for recipients over the age of 21.

If you need a service that is not listed above call the referral assistance coordinator at Kidmed (toll free) 1-877-455-9955 (or TTY 1-877-5449544). If they cannot refer you to a provider of the service you need call 225-342-5774

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If you are a Medicaid recipient, under age 21, and are on the waiting list for the MR/DD waiver, you may be eligible for Support coordination services. To access these services, you must contact your Regional Office for Citizens with Developmental Disabilities office.

You may access other services by calling KIDMED at (toll-free) 1-877-455-9955. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

Some of these services must be approved by Medicaid in advance. Your medical provider should be aware of which services must be pre-approved and can assist you in obtaining those services. Also, KIDMED can assist you or your medical provider with information as to which services must be pre-approved.

Whenever health treatment or additional services are needed, you may obtain an appointment for a screening visit by contacting KIDMED. Such screening visits also can be recommended by any health, developmental, or educational professional. To schedule a screening visit, contact KIDMED at (toll-free) 1-800-259-4444 (or 928-9683, if you live in the Baton Rouge area), or by contacting your physician if you already have a KIDMED provider. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

Louisiana Medicaid encourages you to contact the KIDMED office and obtain a KIDMED provider so that you may be better served.

If you live in a CommunityCARE parish, please contact your primary care physician for assistance in obtaining any of these services or contact KIDMED at (toll-free) 1-877-455-9955.

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)/DISTRICT/AUTHORITY

METROPOLITAN HUMAN SERVICES DISTRICT
1010 Common Street, 5th Floor
New Orleans, LA 70112
Telephone: (504) 599-0245
FAX: (504) 568-4660
Toll Free: 1-800-889-2975

CAPITAL AREA HUMAN SERVICES DISTRICT
4615 Government St. - Bin #16 - 2nd Floor
Baton Rouge, LA 70806
Telephone: (225) 925-1910
FAX: (225) 925-1966
Toll Free: 1-800-768-8824

REGION III
690 E. First Street
Thibodaux, LA 70301
Telephone: (985) 449-5167
FAX: (985) 449-5180
Toll Free: 1-800-861-0241

REGION IV
214 Jefferson Street - Suite 301
Lafayette, LA 70501
Telephone: (337) 262-5610
FAX: (337) 262-5233
Toll Free: 1-800-648-1484

FLORIDA PARISHES HUMAN SERVICES AUTHORITY
2154 Koop Drive Suite 2H
Mandeville, LA 70471
Telephone: (985) 871-8300
FAX: (985) 871-8303
Toll Free: 1-800-866-0806

REGION VI
429 Murray Street - Suite B
Alexandria, LA 71301
Telephone: (318) 484-2347
FAX: (318) 484-2458
Toll Free: 1-800-640-7494

REGION VII
3018 Old Minden Road Suite 1211
Bossier City, LA 71112
Telephone: (318) 741-7455
FAX: (318) 741-7445
Toll Free: 1-800-862-1409

REGION VIII
122 St. John St. - Room 343
Monroe, LA 71201
Telephone: (318) 362-3396
FAX: (318) 362-5305
Toll Free: 1-800-637-3113

REGION V
3501 Fifth Avenue, Suite C2
Lake Charles, LA 70607
Telephone: (337) 475-8045
FAX: (337) 475-8055
Toll Free: 1-800-631-8810

JEFFERSON PARISH HUMAN SERVICES AUTHORITY
3300 W. Napoleon Ave - Ste.213
Metairie, LA 70002
Telephone: (504) 838-5357
FAX: (504) 838-5400

The Louisiana Nursing Facility Level of Care Eligibility Tool

Effective December 2006, the Louisiana Department of Health and Hospitals began implementing the Louisiana Nursing Facility Level of Care Eligibility Tool (LOCET) as a new instrument use to determine levels of care for all long term care services which require a nursing facility level of care. The LOCET may be used in conjunction with additional assessment and screening tools.

A LOCET interview will be conducted for all persons who apply for any long-term care program administered by the Office of Aging and Adult Services (OAAS): Elderly and Disabled Adult Waiver Services, Adult Day Health Care Services, Long Term Personal Care Services and Nursing Facility Admissions. The LOCET determination replaces the use of the Form 90-L or 90-PCS in these situations.

The purpose of this level of care determination is to assure that individuals meet the medical necessity requirements for admission to and continued stay in long term care programs. The LOCET's determination is based upon findings discovered by use of the Minimum Data Set Assessment® tool and is formulated from the following areas on the Minimum Data Set Assessment tool and additional assessments:

- Activities of Daily Living
- Cognitive Function
- Skilled Rehabilitative Services
- Physician Involvement
- Behavior
- Treatments and Conditions
- Service Dependency

Please visit our website at www.ltss.dhh.louisiana.gov for specific information about the LOCET process as it relates to the various programs noted above, as well as a listing of Frequently Asked Questions.

Physician and Hospital Providers

HIGH LEVEL EMERGENCY ROOM VISITS

Louisiana Medicaid established billing procedures for identification of high-level emergency room visits (99283-99285) and associated services effective for dates of services on and after July 1, 2002.

- Physicians billing on the CMS-1500 should put a "3" in locator 24i to identify all services associated with a high-level emergency room visit.

- Hospitals billing on the UB-92 should put a "3" in locator 11 to identify all services associated with a high-level emergency room visit.

It has come to our attention that some providers are billing low level emergency room visits with the high level emergency room indicator. **The use of the "3" with low level (99281-99282) emergency room visits and associated services is considered fraudulent billing and is subject to recoupment.** In keeping with this policy, DHH has implemented CommunityCARE error edit 104 (Indicator 3 invalid with CPT codes/PCP referral required). High-level emergency room visits do not require post-authorization by CommunityCARE Primary Care Providers (PCP).

Effective with dates of service December 1, 2006, low-level (99281-99282) emergency room visits inappropriately billed with the "3" indicator will deny. Questions regarding this policy should be directed to Unisys Provider Relations.

Professional Services

Pre-Certification Policy Clarification

When a hospital's pre-certification or extension request is denied because it does not meet the pre-certification criteria for medical necessity, neither the hospital nor the physician services are payable. The recipient may not be billed in these circumstances.

If the hospital fails to timely request pre-certification or an extension for a hospital stay, the physician may be paid. However, these claims require special handling and will be reviewed for medical necessity. Providers should send their claims, with admit and discharge summaries attached, and a cover letter requesting pre-certification override to:

UNISYS Provider Relations Correspondence Unit
P. O. Box 91024
Baton Rouge LA 70821

Complete Pre-Certification policy may be found on pages 70-71 of the **2006 Louisiana Medicaid Professional Services Provider Training** manual, which is also available on-line at www.lamedicaid.com under the **Training** link.

2006 AMERICAN DENTAL ASSOCIATION CLAIM FORM

Effective January 1, 2007, Medicaid began accepting the new 2006 American Dental Association (ADA) Claim Form from providers who submit hardcopy claims to Medicaid for prior authorization and payment of dental services. In addition, Medicaid will continue to accept the 2002 ADA Claim Form and the 2002, 2004 ADA Claim Form through April 1, 2007.

Effective April 2, 2007, the 2006 ADA Claim Form will be required when submitting hardcopy claims to Medicaid and will be the only dental claim form accepted for prior authorization and payment of dental services. Effective April 2, 2007, all 2002 ADA Claim Forms and all 2002, 2004 ADA Claim Forms received by the Medicaid Dental Prior Authorization Unit or Unisys will be returned to the provider unprocessed.

All providers who submit hardcopy dental claims will be responsible for submitting the 2006 ADA Claim Form effective April 2, 2007. No exceptions will be made.

In preparation, providers who submit hardcopy claims to Medicaid should order the 2006 ADA Claim Forms from the ADA or their dental supplier as soon as possible. Providers who use dental software to print hardcopy dental claims should contact their software vendor as soon as possible in order to obtain the 2006 dental software. Providers who use a third party contractor (billing agent) should provide their contractor with a copy of this message.

Dental providers should check this website (www.lamedicaid.com) periodically for new updates on this topic.

Invalid ICD-9 Diagnosis And Surgical Procedure Codes

Earlier last year, Louisiana Medicaid informed providers that error code 433, (missing/invalid diagnosis code) would be an "educational only" edit for claims with invalid diagnosis and surgical procedure codes until March 1, 2006. Providers have had ample time to make the necessary changes in their claim filing system. Therefore effective **February 1, 2007**, claims with invalid diagnosis and surgical procedure codes will deny with error code 433.

Please note that a three-digit diagnosis code should be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth digit sub classifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code.

For information regarding the ICD-9-CM Official Guidelines for Coding and Reporting, providers may access the CMS website at www.cms.hhs.gov/icd9providerdiagnosticcodes/ or the CDC website at http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide06.pdf

If you are unable to click on the URL directly, type the URL into your web browser.

National Drug Codes Required on Physician Administered Drug Claims

The Deficit Reduction Act of 2005 (DRA) includes provisions regarding physician-administered drugs and the collection of Medicaid drug rebates from manufacturers. Currently physician-administered drugs are billed to Medicaid using HCPCS codes. To secure rebates for physician administered drugs, the federal statute requires the use of National Drug Codes (NDC) for drug products administered in the physician's office.

The NDC number **and** HCPCS code for drug products will be required on both the 837P (electronic form) and the CMS-1500 (paper form). This requirement will begin on **April 2, 2007** with implementation of the new CMS-1500 form.

Providers must update their billing software to ensure that these federal requirements are met. Providers should monitor www.lamedicaid.com for specific policy and billing instructions.

NOTICE TO PHYSICIANS: REGIONAL LADUR COMMITTEE

The Department of Health and Hospitals is currently accepting nominations for the **Region 1 Drug Utilization Review Committee**. The committee consists of three pharmacists and one physician who meet monthly to review clinical issues on recipient drug profiles and send information to the medical community. One physician opening is currently available.

Committee members must be available to meet monthly for one to three hours and must meet the following requirements:

- Doctor of medicine degree from an accredited U.S. medical school
- Licensed to practice medicine in Louisiana
- No previous sanctions from the state of Louisiana
- Provide services to Louisiana Medicaid recipients
- Practice in one of the following parishes:

East Jefferson Orleans Plaquemine St. Bernard St. Charles
St. Tammany Tangipahoa Washington West Jefferson

Please use the form below for your nomination and return with a brief resume to:

Unisys: Louisiana Medicaid
8591 United Plaza Blvd., Suite 300
Baton Rouge, LA 70809
ATTN.: S. DELAVILLE

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LMMIS REGION ONE DRUG UTILIZATION REVIEW COMMITTEE
NOMINATION- PHYSICIAN (PLEASE PRINT OR TYPE)

NAME: _____PHONE: _____

ADDRESS: _____

_____

PARISH: _____EMPLOYER: _____

PRACTICE or SPECIALTY: _____

I am nominating the above mentioned for consideration as a member of the **LMMIS REGION ONE DRUG UTILIZATION REVIEW COMMITTEE.**

PRINT NAME: _____

SIGNATURE: _____PARISH:_____

NOTICE TO PHYSICIANS: REGIONAL LADUR COMMITTEE

The Department of Health and Hospitals is currently accepting nominations for the **Region 3 Drug Utilization Review Committee.** The committee consists of three pharmacists and one physician who meet monthly to review clinical issues on recipient drug profiles and send information to the medical community. One physician opening is currently available.

Committee members must be available to meet monthly for one to three hours and must meet the following requirements:

- Doctor of medicine degree from an accredited U.S. medical school
- Licensed to practice medicine in Louisiana
- No previous sanctions from the state of Louisiana
- Provide services to Louisiana Medicaid recipients
- Practice in one of the following parishes:

Acadia	Allen	Beauregard	Calcasieu	Cameron	Evangeline
Iberia	Jefferson Davis	Lafayette	St. Landry	St. Martin	St. Mary
Vermillion	Winn				

Please use the form below for your nomination and return with a brief resume to:

Unisys: Louisiana Medicaid
8591 United Plaza Blvd., Suite 300
Baton Rouge, LA 70809
ATTN.: S. DELAVILLE

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LMMIS REGION THREE DRUG UTILIZATION REVIEW COMMITTEE
NOMINATION- PHYSICIAN (PLEASE PRINT OR TYPE)

NAME: _____PHONE:_____

ADDRESS: _____

_____

PARISH_____EMPLOYER: _____

PRACTICE or SPECIALTY: _____

I am nominating the above mentioned for consideration as a member of the **LMMIS REGION THREE DRUG UTILIZATION REVIEW COMMITTEE.**

PRINT NAME: _____

SIGNATURE:_____Parish_____

NOTICE TO PHARMACISTS: REGIONAL LADUR COMMITTEE

The Department of Health and Hospitals is currently accepting nominations for the **Region 4 Drug Utilization Review Committee.** The committee consists of three pharmacists and one physician who meet monthly to review clinical issues on recipient drug profiles and send information to the medical community. One pharmacist opening is currently available.

Committee members must be available to meet monthly for one to three hours and must meet the following requirements:

- Pharmacy degree from an accredited U.S. pharmacy school
- Licensed to practice pharmacy in Louisiana
- No previous sanctions from the state of Louisiana
- Provide services to Louisiana Medicaid recipients
- Practice in one of the following parishes:

Avoyelles	Bienville	Bossier	Caddo	Caldwell	Catahoula
Claiborne	Concordia	Desoto	East Carroll	Franklin	Grant
Jackson	LaSalle	Lincoln	Madison	Morehouse	Natchitoches
Ouachita	Rapides	Red River	Richland	Sabine	Tensas
Union	Vernon	Webster	West Carroll		

Please use the form below for your nomination and return with a brief resume to:

Unisys: Louisiana Medicaid
8591 United Plaza Blvd., Suite 300
Baton Rouge, LA 70809
ATTN.: S. DELAVILLE

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LMMIS REGION FOUR DRUG UTILIZATION REVIEW COMMITTEE NOMINATION- PHARMACIST (PLEASE PRINT OR TYPE)

NAME: _____PHONE:_____

ADDRESS: _____

_____

PARISH: _____EMPLOYER: _____

I am nominating the above mentioned for consideration as a member in the **LMMIS REGION FOUR DRUG UTILIZATION REVIEW COMMITTEE.**

PRINT NAME: _____

SIGNATURE:_____ PARISH:_____

Contact Information

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**
Pharmacy Hot Line	**1-800-437-9101**

Influenza

Hilary Tice, Pharm.D.
ULM Assistant Professor, Pediatrics
Clinical and Administrative Sciences

Issues

- Influenza viral infections remain a significant source of morbidity and mortality in the United States.
- Second-generation antihistamines are preferred over first-Immunity from influenza vaccination wanes within a year.
- Influenza vaccine is reformulated each year to keep pace with the antigenic drift that occurs from influenza virus mutations.
- Administration guidelines for the 2006-2007 season have been updated, increasing the percentage of Americans eligible for the vaccination.

Etiology

Influenza viruses are part of the Orthomyxoviridae family of viruses and are single-stranded RNA viruses with a segmented genome encased in a lipid-containing envelope. There are 3 types of influenza viruses: A, B and C. A and B are associated with most disease in humans. Influenza A is further divided into subtypes based on surface antigens: hemagglutinin and neuraminidase. These antigen subtypes project as spikes through the viral surface allowing the virus to invade host cells (hemagglutinin) and then leave host cells (neuraminidase).

The main mechanism for emergence of new influenza strains each year results from antigenic drift causing minor changes within a serotype. Influenza B viruses undergo antigenic drift less rapidly than influenza A viruses. The influenza virus will occasionally undergo antigenic shift which causes major changes in serotype.

Clinical Manifestations

Influenza is spread horizontally from person-to-person via respiratory droplets. Influenza infections predominate in the respiratory tract. Signs and symptoms of infection include: abrupt onset, cold like symptoms, conjunctival inflammation, pharyngitis and dry cough with systemic signs of high temperature, muscle aches, fatigue and headache. Children normally experience otitis media, nausea and vomiting concurrently with infection.

The virus will incubate 1to 4 days, with an average of 2 days, before signs and symptoms become apparent. Adults are contagious the day prior to symptom onset through approximately 5 days after. Children can spread disease 10 or more days after symptom onset with very young children shedding virus prior to symptom onset. Immunocompromised individuals may be contagious for weeks to months after infection. In immunocompetent individuals, illness usually lasts 3 to 7 days with cough and muscle pain persisting for more than 2 weeks. Prognosis is excellent, with full recovery expected in weeks. Complications, hospitalizations and deaths are higher among individuals 65 and older, young children, and persons of any age with high risk health conditions.

Lab tests

There are several lab tests available to utilize in diagnosing influenza. Currently available tests include: viral culture, serology, rapid antigen testing, polymerase chain reaction and immunofluorescence assays. Several rapid diagnostic tests (detection of influenza viruses in 30 minutes) are available with differences in sensitivity and specificity for the influenza A and B virus and the type of specimen analyzed by the test. The types of specimens that can be utilized for analysis are: nasopharyngeal swabs, throat swabs, nasal wash, bronchial wash, nasal aspirate, sputum, and paired acute and convalescent specimens. In general, nasopharyngeal specimens are more effective than throat swab specimens.
Detailed information pertaining to the different types of diagnostic tests can be found at the CDC website: http://www.cdc.gov/flu/professionals/labdiagnosis.htm.

Prevention

There will be an estimated 110 to 115 million doses of vaccine available this season, which is 5 to 10 million doses above the availability seen during the previous season. Most of the vaccine supply for this year has been pre-booked; therefore, practitioners may have problems finding supply later in the year. These doses will come from inactivated, live and thimerosal-free products. There should be 8-9 million doses of thimerosal-free product available; however, the CDC anticipates that there will be insufficient thimerosal-free vaccine for children 3 years old due to the addition of this age group into the 2006 to 2007 ACIP recommendations after the vaccine supply for the year was set.

Recommendations from the FDA's Vaccines and Related Biological Products Advisory Committee (VRBPAC) stated that vaccines for use in the US 2006-2007 season should contain the following influenza viral components:

- an A/New Caledonia/20/99 (H1N1)-like virus;
- an A/Wisconsin/67/2005 (H3N2)-like virus (A/Wisconsin/67/2005 and A/Hiroshima/52/2005strains);
- a B/Malaysia/2506/2004-like virus (B/Malaysia/2506/2004 and B/Ohio/1/2005 strains).

The official start of the vaccination season begins in October/November; however, providers may opt to vaccinate certain individuals beginning in September. Vaccination during September can be considered for 1) persons at increased risk for serious complications and their household contacts (including out-of-home caregivers and household contacts of children aged 0-59 months); however, in facilities housing older persons, vaccination before October should be avoided because antibody levels in these individuals can begin to decline more rapidly after vaccination; and 2) vaccine naïve children 6 months to 9 years old who will need 2 doses of vaccine. Vaccination should continue throughout the season even after there is documented influenza activity in the community.

Both inactivated and live preparations are made from egg-grown viruses. The live product is given intranasally via sprayer whereas inactivated products are given IM. When comparing indications, the live product is only approved for healthy individuals 5-49 years of age whereas the inactivated product may be used in healthy and higher risk individuals aged 6 months and older.

Current Recommendations for using Influenza Vaccines

Indications	Changes and updates in the 2006-2007 ACIP recommendations	Persons who should NOT be vaccinated with Live Attenuated Influenza Vaccine (LAIV)
*Children 6-59 months *Women who will be pregnant during the influenza season *Persons aged 50 yrs and above *Individuals 6 months – 18 years who are receiving long-term aspirin therapy placing them at risk for experiencing Reye syndrome after influenza infection *Individuals with chronic pulmonary and cardiovascular disease (includes asthma, excludes hypertension) *Individuals with a history of medical follow-up or hospitalization during the previous year resulting from chronic metabolic diseases, renal dysfunction, hemoglobinopathies, or immunodeficiency (including HIV or medication initiated immunodeficiency) *Individuals with neurological complications that can lead to altered respiratory function, respiratory secretions or aspiration *Residents of long-term care facilities housing individuals of any age with chronic medical conditions *Caregivers of persons at high risk for influenza-related complications, including healthy household contacts and caregivers of children aged 0-59 months *Healthcare workers	*Children 6-59 months of age were added *Removal of prioritization as the default from the influenza vaccine recommendations for 2006 *Recommendations to vaccinate household contacts and out-of-home caregivers of healthy children 24-59 months were added *Vaccine naïve children from 6 months up to 9 years should receive 2 doses of vaccine. Booster doses of inactivated or live formulations should be given to children aged 6 months to 9 years and 5 to 9 years, respectively. Second doses should be given prior to influenza season but separated by 1 month or longer if inactivated vaccine was given or by 6-10 weeks if live vaccine was administered. For children 6 months to 9 years who received one dose of vaccine for the first time during the previous season, only 1 dose of vaccine should be administered for the current season *Expansion of outreach programs, bolstering of infrastructure, and contingency plan development should be initiated by health-care providers, those planning organized campaigns, and state & local public health agencies, in preparation for delayed &/or reduced vaccine supply *Influenza vaccine should be offered throughout the influenza season *Due to reported resistance, amantadine or rimantadine should NOT be used for the treatment or prevention of influenza A in the US	*Persons younger than 5 yrs or 50 yrs and older. *Persons with respiratory disease or other chronic disorders of the lungs or cardiovascular system, metabolic disease or those with immunodeficiency *Children or adolescents taking salicylates *Individuals with a history of *Guillain-Barre' Syndrome* (GBS) *Pregnancy *Persons with a history of type I allergies to any components of LAIV or to eggs

Influenza vaccination in persons infected with HIV are most effective with CD4+ T-lymphocyte counts greater than 100 cells and among those with less than 30,000 viral copies of HIV type-1/mL. Inactivated vaccine and booster doses may not provide protection to HIV infected individuals with advanced disease and low CD4+ T-lymphocyte cell counts.

Vaccination may be beneficial for travelers with high risk conditions who did not receive vaccination during the previous year and are traveling to the tropics, with organized tourist groups or to the southern hemi-sphere during April-September.

Treatment

There are four primary drugs used in treatment of influenza infection. These agents are zanamivir/Relenza®, oseltamivir/Tamiflu®, amantadine/Symmetrel® and rimantadine/Flumadine®. Amantadine and rimantadine are no longer recommended due to increased resistance seen in the community. The CDC reported that 92% of patients in 26 states demonstrated a change in the amino acids of Influenza A strains which conferred resistance to adamantanes. Resistance to neuraminidase inhibitors, zanamivir and oseltamivir, has also been identified but does not appear to be as frequent as with the adamantanes.

When administered within 2 days of illness onset to otherwise healthy adults, zanamivir and oseltamivir can reduce the duration of uncomplicated influenza A and B illness by approximately 1 day. The recommended duration of treatment with either zanamivir or oseltamivir is 5 days. Neuraminidase inhibitors have been shown to decrease the risk for pneumonia and hospital admissions by 50%, which may benefit high-risk patients. Inadequate data exists regarding the safety and efficacy of any of the influenza antiviral drugs for use among children younger than 1 year.

When influenza vaccine is administered during an active season, chemoprophylaxis should be considered for persons at high risk during the time from vaccination until immunity has developed. Immunity usually develops in 2 weeks; however, children younger than 9 years who receive influenza vaccine for the first time may require 6 weeks of chemoprophylaxis after the second vaccine dose. Chemoprophylaxis during peak influenza activity can be considered for unvaccinated persons who have frequent contact with persons at high risk or during an outbreak caused by a non-vaccine strain of influenza. Chemoprophylaxis should be considered for all individuals, regardless of their vaccination status. Chemoprophylaxis can also be considered for persons at high risk who are prone to having low antibody response to vaccination, including individuals infected with HIV.

Detailed information pertaining to dosing schedules can be found at: http://www.cdc.gov/flu/professionals/treatment/dosage.htm.

Internet resources for Influenza information:

- CDC website. Flu Vaccination Resources for Health Care Professionals. Available at: http://www.cdc.gov/flu/professionals/vaccination/

- American Medical Association web site. Influenza Vaccine Availability Tracking System. Available at: http://www.ama-assn.org/ama/pub/category/16919.html

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5) CDC website. Questions & answers: Influenza vaccine production, supply & distribution in the US. Available at: http://www.cdc.gov/flu/about/qa/vaxsupply.htm

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8) Immunization action coalition. Ask the experts: Influenza. Available at: http://www.immunize.org/catg.d/p2021e.htm

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Dental	**1-504-619-8589**		
DME & All Other	**1-800-488-6334** **(225) 928-5263**	**Point of Sale Help Desk**	**1-800-648-0790** **(225) 216-6381**
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