Louisiana Medicaid

Provider Update

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Louisiana Medicaid Announces New Claims Editing Capabilities

In May 2010, Louisiana Medicaid anticipates implementation of the McKesson ClaimCheck® claims editing product and the Clear Claim Connection™ provider reference tool to improve the accuracy and consistency of processing claims. These products will supplement the current claims processing system, especially in relation to professional and outpatient hospital claims.

The ClaimCheck software is designed to evaluate billing information and coding accuracy on submitted claims. ClaimCheck's procedure edits are guided by widely accepted industry practices and compares submitted claims to standard American Medical Association (AMA) Current Procedural Terminology (CPT) coding guidelines, many Centers for Medicare and Medicaid (CMS) standards, and specialty society standards. The software introduces an automated method to aid in the application of Medicaid medical and claims policies and allows for consistent and accurate processing of claims. It is designed to detect irregularities such as unbundling, mutually exclusive procedures, and incidental procedures. ClaimCheck also evaluates coding accuracy in areas such as pre and post surgery periods, modifier usage, and assistant surgery editing.

Clear Claim Connection is a web-based reference tool that will be available on the Medicaid website to enable providers to access editing rules and the clinical rationale for the ClaimCheck edits.

In preparation for the implementation, Louisiana Medicaid policies will be reviewed and modification of existing policies may be necessary. Providers will be notified of any policy changes and updates regarding the progress of implementation through a link on our website (www.lamedicaid.com), remittance advice messages, and/or other forms of provider communication. Providers should monitor the website regularly for the most up-to-date information.

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Medicaid Number Assignment

Louisiana Medicaid is changing the way new providers will be assigned a Medicaid Provider Identification Number. Under the current numbering system, providers approved for enrollment are assigned a 7-digit Louisiana Medicaid ID number in addition to their National Provider Identifier (NPI). Current provider numbers begin with a "1" as the first digit of the number. However, due to a shortage of available numbers, newly enrolled providers will be issued a provider number that begins with a "2".

Medicaid converted all systems to begin accepting this new numbering system at the end of 2009. Provider numbers with a leading number "1" will continue to be valid and accepted. Vendors, billing agents, and clearinghouses working with Louisiana Medicaid providers should review their individual systems, processes and procedures to accommodate this change. For additional information, please visit the LaMedicaid website at www.lamedicaid.com.

Medicaid Provider Manual Chapters Go Online

Providers can expect to see changes in how they obtain and view the manual chapters that govern the programs in which they are enrolled. Louisiana Medicaid is currently working to update each chapter in its Medicaid provider manual. Once a chapter is updated, it will be available to providers on the Louisiana Medicaid website at www.lamedicaid.com under the "Provider Manual" link. All revisions to each chapter will also be available online which will allow providers to have the most current policy information.

The following is a list of manual chapters that are currently available online:

- American Indian 638 Clinics,
- Mental Health Rehabilitation,
- Multi-Systemic Therapy, and
- Personal Care Services.

Providers will be notified through Remittance Advice messages and future *Provider Update* articles when additional chapters are published.

Providers of Childhood Immunizations

New Vaccine Booster for Haemophilus Influenzae Type b (Hib) Available

A new vaccine booster for children age 15 months through 4 years for the *Haemophilus influenzae* type b (Hib) immunization services is available from the Vaccines for Children (VFC) Program. The American Medical Association (AMA) has released guidance for the use of the Current Procedural Terminology (CPT) procedure code 90648 for reporting the use of this Hib booster vaccine for the booster (final) dose of the Hib immunization series (see CPT Assistant, September 2009). Louisiana Medicaid follows this guidance from the AMA. Providers of childhood vaccines should use CPT code 90648 for reporting this vaccine. If nationally approved changes occur to CPT codes at a future date, providers are to follow the most accurate coding available for covered services, unless otherwise directed.

Louisiana Medicaid will reimburse providers only for the administration of the vaccine, as the vaccine is available from the Louisiana VFC program at no charge to VFC enrolled providers. Providers with billing or policy questions should contact Unisys Provider Relations at (800) 473-2783 or (225) 924-5040. Questions related to this vaccine, including its availability, should be directed to the Louisiana Office of Public Health-Immunization Program at (504) 838-5300.

KIDMED Providers

Revised KIDMED RS-O-07 Reports Implemented and Guidelines for Determining Dates Used In RS-O-07 Reports

Louisiana Medicaid has completed additional revisions to the KIDMED series of RS-O-07 screening reports to better reflect the status of screenings for linked providers. These new reports were posted for December 2009. The reports include:

RS-O-07-1 - **Initial Screen Due Now**: This report includes only those recipients linked to the provider at the time of the report and no medical screening by any provider is found in claims history. The Next Screen Period has a "begin" date based on the effective date of linkage to the provider receiving the report and an "end" date that includes a "grace" period to perform the Initial Screen as identified in KIDMED policy. (The "grace" periods are indicated below.)

Note: **Initial Screenings** are identified by the **absence** of a **Last Screen Date and** the **Next Screen Period Begin Date** is set to the provider's linkage begin date.

All Other Screenings are identified by the **presence** of a **Last Screen Date**.

RS-O-07-2 - Screen Overdue: This report includes those recipients whose "end" date for the Next Screen Period has passed, and may include recipients previously reported on the RS-O-01 report.

RS-O-07-3 - Screen Due This Month: This report will include those recipients whose Next Screen Period includes the current month in the range.

RS-O-07-4 - Up To Date: This report includes those recipients whose "begin" date of the Next Screen Period is in the future and does not include the current month.

RS-O-07-5 - Last Month On Report: This report includes only those recipients who are linked to the provider for the current report month but will not be linked to this provider the following month due to: (1) a change in provider linkage; (2) aging out of KIDMED (turning 21years during this month); or (3) loss of Medicaid eligibility.

RS-O-07-6 - Comprehensive Listing of Recipient/Screening: This report includes ALL recipients linked to the provider and includes the Next Screen Period range.

RS-O-07-R - KIDMED Roster: This report includes ALL recipients linked to the provider but DOES NOT include the Next Screen Period range. This report lists on which of the RS-O-07 reports the recipient appears.

Note: With the exception of RHC/FQHC KIDMED encounters, only PAID screenings appear on these reports. Denied screenings must be corrected where appropriate and resubmitted for payment to be captured and included on the RS-O-07 reports.

Grace Periods for Initial Screenings:
Per current KIDMED policy a "grace" period of 45, 60, or 120 days from the date of recipient linkage to the KIDMED provider is included to allow providers time to schedule and perform the **initial** screening and is based on the recipient's age at the time the KIDMED linkage is made. The 'grace periods' are as follows:

Less Than 2 Years	+45 Days
Equal To or Greater Than 2 Years AND Less Than 6 Years	+60 Days
Equal To or Greater Than 6 Years	+120 Days

Guidelines for Date Calculations on the RS-O-07-1 through RS-O-07-5

Initial Screenings - Identified by the absence of a Last Screen Date

1. Next Screen Period Begin Date

Next screen period begin date is set to the providers linkage begin date.

2. Next Screen Period End Date

Next screen period end date is calculated as 45, 60 or 120 days after the next screen period begin date based on the recipients' age on the **next screen period** begin date as follows:

Age	Days
< 2 years	+ 45 days
= or > 2 years and < 6 years	+ 60 days
= or > 6 years	+ 120 days

All Other Screenings - Identified by the presence of a Last Screen Date

1. Next Screen Period Begin Date

Age at last screening is calculated as the difference in years and months (YYMM) between the recipients DOB and the date of last screening.

The resulting YYMM is compared to the screening periodicity table to determine in what screening period the last screening was performed. The period following the last screen period in the periodicity table is established as the "target period" to be reported.

Next screen period begin date is calculated by adding the number of years of the "target period" to the YYYY portion and of the recipients birth date and adding number of months of the "target period" to the MM portion of the recipients birth date (**next screen period begin date** falls on the recipients year or month birthday).

If the resulting date has an invalid DD (for example 2009/02/30), the date is re-calculated as the first day of the following month (2009/03/01 in this example).

2. Off Schedule Screenings

For children under age 2, there must be at least 30 days between screenings and for children 2 years and older, there must be at least 6 months between screenings.

For children under age 2 on the **next screening period begin date** established above:

> If the **next screen period begin date** is less than 30 days greater than the last screen date, the last screening is considered to have been "off schedule" and the **next screen period begin date** is re-calculated as last screen date + 30 days.

For children age 2 years and older on the **next screen period begin date** established above:

> If the **next screen period begin date** is less than 6 months greater than the last screen date, the last screening is considered to have been "off schedule" and the **next screen period begin date** is re-calculated by adding 6 to the MM (month) portion of the last screen date.
>
> If the resulting date has an invalid day, DD in the date format YYYY/MM/DD, (for example 2009/02/30), the date is re-calculated as the first day of the following month (2009/03/01 in this example).

3. Next Screen Period End Date

The **next screen period end date** is calculated by calculating the period begin date for the screening period following the "target period". This calculation is done in the same manner as described in number 1 above.

One day is subtracted from this date resulting in a **next screen period end date** that is the last day of the "target period".

If the resulting date has an invalid DD (for example 2009/02/30), the date is re-calculated as the last valid day of the month (2009/02/28 in this example).

If the **next screen period end date** is greater than the last day of the month of the recipients 21st birthday, **next screen period end date** is re-calculated as the last day of the month of the recipients 21st birthday.

If the provider has an established linkage end date and the **next screen period end date** is greater than the linkage end date, the **next screen period end date** is re-calculated to be the providers' linkage end date.

If a recipient has received their 20 year screening, **next screen period begin date** and **next screen period end date** are not printed on the reports, instead a message "20 YR SCREEN COMPLETE" is printed.

EPSDT Screening Claims: Definition by procedure code

Screening Type	Procedure Codes
Medical Screening	99381 thru 99385, 99391 thru 99395
Vision Screening	99173
Hearing Screening	92551

Human Papillomavirus: Focus on Prevention

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Human Papillomavirus (HPV)

Genital HPV is the most common sexually transmitted infection (STI) in the United Sates, with an estimated 6.2 million new infections occurring annually.[1] Papillomaviruses initiate infection in the basal layer of the epithelium causing normally nondividing epithelial cells to remain in an active cell cycle; this may result in a thickened epithelial lesion. Because papillomaviruses are restricted to the epilthelium, HPV infections are largely shielded from the host immune response, although 90% of cases are cleared naturally.[2,3] HPV is transmitted by direct contact, usually sexual, with an infected person. Transmission occurs most frequently with sexual intercourse but may occur following nonpenetrative sexual activity. The affected genital areas of men and women include the skin of the penis, vulva, and anus, as well as the linings of the vagina, cervix, and rectum.[4]

Many HPV types have been identified; over 40 types affect the epithelial mucosa.[2] (See Table 1) Genital wart-causing HPV types are often referred to as "low-risk" and cancer-causing HPV types as "high-risk." High-risk HPV types are detected in 99% of cervical cancers with types 16 and 18 together accounting for approximately 70% of cases.[2] With 30% of cervical cancers caused by HPV types that are not contained in available vaccines, cervical cancer screening programs are still a necessity.[5]

Genital Warts

Population-based estimates, primarily from clinics treating persons with STIs, indicate that about 1% of the sexually active adolescent and adult population in the United States have clinically apparent genital warts. All anogenital warts are caused by HPV, and approximately 90% are associated with HPV types 6 and 11.[2] After infection with HPV types 6 or 11, the average time to development of new anogenital warts is 2 to 3 months. However, not all persons infected with HPV types 6 or 11 acquire genital warts due to the body's ability to clear the infection. And unlike cervical cancer, anogenital warts can be treated locally.[3]

Typically appearing externally as painless, pink or flesh colored swellings of the skin of the genital region, perineum, and perianal region, genital warts can appear singly or in clusters. Genital warts can also manifest internally on the cervix, vaginal walls, and anus or within the urethra, in which case the patient is unlikely to be aware of the infection. Signs of infection may take months to appear or the infected person may never develop symptoms. Viral transmission may occur despite a lack of visible signs of infection.[6]

Cervical Cancer

The American Cancer Society estimates that in 2009, 11,270 cases of invasive cervical cancer are expected to be diagnosed and 4,070 deaths from cervical cancer are expected. Over the past several decades, mortality rates due to cervical cancer have declined steadily due to prevention and early detection as a result of screening.[7]

The primary cause of cervical cancer is infection with certain types of HPV.[7] Uncomplicated HPV infection in the lower genital tract can progress to cervical intraepithelial neoplasia (CIN). This lesion precedes invasive cervical carcinoma and is classified as low-grade squamous intraepithelial lesion (SIL), high-grade SIL, and carcinoma in situ. Carcinoma in situ demonstrates cytologic evidence of neoplasia without invasion through the basement membrane and can persist unchanged for 10 to 20 years, but most of these eventually progress to invasive carcinoma. Approximately 70% of invasive cervical cancers are squamous cell tumors, 20 to 25% are adenocarcinomas, and 2 to 5% are adenosquamous with epithelial and glandular structures.[8]

It is important to note that HPV infections are common in healthy women and only rarely result in cervical cancer. Risk factors for HPV infection and cervical cancer include having sex at an early age and/or having multiple sexual partners. However, a woman may be infected with HPV even if she has had only one sexual partner.[7] Persistent HPV infection is the most important risk factor for the development of precancerous cervical lesions while immunosuppression, multiple pregnancies, and cigarette smoking may influence progression of precancerous lesions to cervical cancer.[2,7]

Prevention of HPV in Females

While physical barriers such as condoms may reduce the risk of HPV transmission, vaccination against pathologic HPV appears to be an effective cervical cancer prevention strategy.[2,8] Vaccines are made with inactivated virus-like particles that are noninfectious but highly immunogenic. Despite a history of genital warts, abnormal Papanicolaou test, or positive HPV DNA test, HPV vaccination is recommended because vaccination may offer protection from HPV types of which the patient is not infected. Ideally, the vaccine should be administered before potential exposure to HPV through sexual activity. However, females who are sexually active should still be vaccinated consistent with age-based recommendations.[9,10]

Currently, one quadrivalent vaccine product (Gardasil®, Merck) containing HPV types 6, 11, 16, and 18 and one bivalent vaccine product (Cervarix®, GlaxoSmithKline) containing HPV types 16 and 18 have been licensed in the United States and recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) for administration to girls and young women.[9,10,11] Gardasil® is approved for the prevention of cervical, vulvar and vaginal cancers caused by HPV types 16 and 18; precancerous or dysplastic lesions caused by HPV types 6, 11, 16, and 18; and genital warts caused by HPV types 6 and 11.[12] Cervarix® is approved for the prevention of cervical cancer and cervical pre-cancers caused by oncogenic HPV types 16 and 18.[13]

In 2007, the CDC reported that 25.1% of adolescent females (13 to 17 years of age) initiated the Gardasil® vaccine series (≥1 dose).[14] A rise in vaccination to 37.2% of adolescent females initiating the vaccination series (≥1 dose) occurred in 2008, with 17.9% of females receiving ≥3 doses. In 2008, vaccine initiation rates for Louisiana were 36.6% compared to 22.4% in Arkansas, 15.8% in Mississippi, and 31.6% in Texas.[15]

HPV vaccination with Gardasil® is FDA-approved for use in all females aged 9 through 26 years. Gardasil® is administered in 3 separate 0.5 mL intramuscular injections in the deltoid region of the upper arm or in the higher anterolateral area of the thigh over a 6-month period at 0, 2, and 6 months.[12] (See Table 2.) The series does not need to be restarted if the schedule is interrupted.[2] The ACIP recommends HPV vaccination at age 11 to 12, although it may be administered as young as 9 years, with catch-up vaccination for 13 to 26 year old females who have not yet received or completed the vaccine series.[2,9,10]

The most commonly reported adverse event associated with Gardasil® vaccination is headache. Fever, nausea, dizziness, injection-site pain, swelling, erythema, pruritus, and bruising are still common, but have been reported less frequently. Syncope, sometimes associated with tonic-clonic movements and other seizure-like activity, has been reported following vaccination. It is recommended that patients undergo observation for 15 minutes after administration to monitor for syncope. When syncope is associated with tonic-clonic movements, the activity is usually transient and typically responds to restoring cerebral perfusion by maintaining a supine or Trendelenburg position.[12]

Women who have had a previously severe reaction to yeast should not receive Gardasil®. And while the vaccine is Pregnancy Category B, there are no well-controlled studies in pregnant women; vaccination during pregnancy should occur only if clearly needed.[12]

In October 2009, the FDA approved a second HPV vaccine, Cervarix®, which provides protection from HPV 16 and 18.[16] The vaccine was approved based on findings from the PATRICIA (PApilloma TRIal against Cancer In young Adults) trial, which demonstrated a vaccine efficacy rate of 93% and suggested additional protection from HPV types not covered by the vaccine (HPV types 31, 33, and 45).[17,18,19] The ACIP also voted to add Cervarix® to its list of recommended HPV immunization options for females. Routine administration is recommended among 11 and 12 year old girls with catch-up vaccination for females 13 to 25 years old who have not previously been vaccinated.[11]

Cervarix® is indicated for the prevention of cervical cancer and cervical pre-cancers caused by oncogenic HPV types 16 and 18, in females 10 to 25 years of age. It is administered as 3 separate 0.5 mL doses by intramuscular injection at 0, 1, and 6 months.[13] (See Table 2.) The preferred site of administration is the deltoid region of the upper arm. Common adverse events include injection site reactions as well as fatigue, headache, myalgia, gastrointestinal symptoms, and arthralgia.[13]

Like Gardasil®, Cervarix® carries a warning regarding the risk of syncope. Both vaccines are Pregnancy Category B and should only be used in pregnancy if clearly needed.[12,13] Each vaccine appears highly effective in preventing its particular HPV infections, and protection has persisted for at least 4.5 years after three injections over a 6-month period.[8] Differences between the vaccines include approved indications, dosing schedule, and approved age of vaccination.[12,13]

Prevention of HPV in Males

Also in October 2009, the FDA approved the use of Gardasil® in males aged 9 - 26 years for the prevention of genital warts caused by HPV types 6 and 11.[20] The decision was based on a phase III study of 4,065 boys and men who were randomized to receive the three-dose Gardasil® vaccine or placebo with the vaccine offering a nearly 90% protection against genital warts.[19] The ACIP voted that Gardasil® should be optional for males rather than part of the approved childhood vaccination schedule.

According to the ACIP, the benefits of vaccinating all boys did not outweigh the costs of such a program.[22] Therefore, male HPV vaccination is left to a physician's discretion or patient/guardian choice.[22]

Table 1 Association of HPV with Clinical Lesions [1]

HPV Type	Clinical Lesion	Suspected Oncogenic Potential
1	Plantar warts	Benign
2, 4, 27, 57	Common skin warts	Benign
3, 10, 28, 49, 60, 76, 78	Cutaneous lesions	Low
5, 8, 9, 12, 17, 20, 36, 47	Epidermodysplasia verruciformis	Mostly benign, but some progress to malignancy
6, 11, 40, 42-44, 54, 61, 70, 72, 81	Anogenital warts; laryngeal papillomas; dysplasias and intraepithelial neoplasias (mucosal sites)	Low
7	Hand warts of butchers	Low
16, 18, 30, 31, 33, 35, 39, 45, 51-53, 56, 58, 59, 66, 68, 73, 82	High-grade dysplasias and carcinomas of genital mucosa; laryngeal and esophageal carcinomas	High correlation with genital and oral carcinomas, especially cervical cancer

Table 2 Gardasil® vs. Cervarix® [12,13]

	Gardasil®	Cervarix®
Indication	Prevention of: • Cervical, vulvar, and vaginal cancer caused by HPV types 16 and 18 • Genital warts caused by HPV types 6 and 11 Prevention of precancerous or dysplastic lesions caused by HPV types 6, 11, 16, and 18: • CIN grade 2/3 and cervical adenocarcinoma in situ • CIN grade 1 • Vulvar intraepithelial neoplasia grade 2 and grade 3 • Vaginal intraepithelial neoplasia grade 2 and grade 3 Prevention of genital warts caused by HPV types 6 and 11 in males 9 to 26 years	Prevention of the following caused by HPV types 16 and 18: • Cervical cancer • CIN grade 2 or worse and adenocarcinoma in situ • CIN grade 1
Approved ages	9 to 26 years	10 to 25 years (females only)
Dosing schedule	0.5 mL IM at 0, 2, and 6 months	0.5 mL IM at 0, 1, and 6 months

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