Louisiana Medicaid

Provider Update

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Budget Deficit Affects Medicaid Providers

Effective January 1, 2011, the Department of Health and Hospitals (DHH) is enacting changes to reimbursement rates for the Medicaid Program to address a $50 million funding deficit caused by unfunded increases in utilization.

Since last year, the Medicaid eligible population has grown 4.4%, driving up utilization of services and program costs. The reduction in reimbursement rates is one of several steps taken by DHH to increase budget sustainability while working to preserve access.

The program reductions range from 2 percent to 5.8 percent for various Medicaid providers. Details of these reductions are published as Emergency Rules on the Louisiana Register's website, (www.doa.louisiana.gov/osr), the state's official journal. Additional efficiencies are set to be achieved through an acceleration of the resource allocation methodology for waiver recipients. The rule changes will address the following services:

- All Inclusive Care for the Elderly
- Ambulatory Surgical Centers
- Early and Periodic Screening, Diagnosis and Treatment - Dental Program
- Early and Periodic Screening, Diagnosis and Treatment - Health Services EarlySteps
- End Stage Renal Disease Facilities
- Home Health - Extended Nursing Services

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A summary of the rules can also be found at www.lamedicaid.com along with the most current fee information. **Questions related to the implementation of these changes and claim adjustments for rate reductions implemented with a December 1, 2010 effective date should be directed to** the Provider Relations Unit at (800) 473-2783 or (225) 924-5040.

CMS Mandate-National Correct Coding Initiative (NCCI) Editing for Medicaid Services

Under new federal regulations signed into law this year, State Medicaid agencies must incorporate and apply editing methodologies of the National Correct Coding Initiative (NCCI) for claims filed on or after October 1, 2010. This Centers for Medicare and Medicaid Services (CMS) program was originally developed to promote national correct coding methodologies and to control improper payments in Medicare Part B claims in 1996. The purpose of the NCCI edits is to prevent the improper payments when incorrect code combinations are reported.

CMS was charged by Congress with the responsibility for defining the adjudication rules, provider types and claim types that will be subject to the NCCI edits by September 1, 2010. On that date, CMS issued a letter of guidance to State Medicaid agencies indicating the NCCI methodologies to be used by Medicaid effective for claims filed on or after October 1, 2010.

Louisiana Medicaid will be required to enforce these edits within the claims processing environment in order to comply with this federal legislation. Louisiana has joined with other state Medicaid agencies to seek further clarification from CMS on the scope of these edits. Because states did not receive details related to this requirement until September 1, 2010 and the complexities that are involved in incorporating these edits into the claims processing systems, CMS has granted states an extension until April 1, 2011 to have these edits implemented in their systems.

These edits pertain to the same patient, same provider on a single date of service, and the types of NCCI edits mandated in the law are:

- Procedure-to-Procedure edits that define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons, and

- Medically Unlikely Edits (MUE) which are units-of-service edits that define for each HCPCS/CPT code the number of units of service beyond which is unlikely to be correct.

Based on the September 1, 2010 CMS letter, claims subject to the NCCI edits include:

- Practitioner,
- Ambulatory surgical center,
- Outpatient hospital services in the outpatient code editor (OCE) for hospitals reimbursed through outpatient prospective payment system (OPPS), and
- Supplier claims for durable medical equipment.

Additional guidance and clarification about NCCI editing will be provided as the information becomes available from CMS. Providers should monitor subsequent RA messages and the Louisiana Medicaid website for the most current information. Providers may also access information on the CMS website at www.cms.gov under the Medicaid links related to NCCI.

Avoid Hiring or Employing Excluded Individuals

As a condition of participation in the Louisiana Medicaid Program, providers are responsible for ensuring that current as well as potential employees and/or contractors have not been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid and/or the Office of Inspector General (OIG). Providers who employ or contract with excluded individuals or entities may be subject to penalties of $10,000 for each item or service the excluded individual or entity furnished.

Providers should check the following two websites prior to hiring or contracting with an individual or entity and should routinely check the websites for determining the exclusion status of current employees and contractors. All current and previous names used such as first, middle, maiden, married or hyphenated names and aliases for **all owners, employees and contractors** should be checked.

- http://exclusions.oig.hhs.gov/search.aspx
- http://www.epls.gov/epls/search.do

If an individual's or entity's name appears on either website, this person or entity is considered excluded and is barred from working with Medicare and/or the Louisiana Medicaid Program in any capacity. The provider must notify the Department of Health and Hospitals with the following information:

- Name of the excluded individual or entity, and
- Status of the individual or entity (applicant or employee/contractor).

If the individual or entity is an employee or contractor, the provider should also include the following information:

- Beginning and ending dates of the individual's or entity's employment or contract with the agency,
- Documentation of termination of employment or contract, and
- Type of service(s) provided by the excluded individual or entity.

These findings should be reported to:

Department of Health and Hospitals
Program Integrity - Special Investigations Unit
P. O. Box 91030
Baton Rouge, LA 70821-9030
Fax: (225) 219-4155

Medicaid providers should review the information provided in the SPECIAL ADVISORY BULLETIN titled "The Effect of Exclusion from Participation in Federal Healthcare Programs" at http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/effected.htm.

Sections E, F, and G of the bulletin explain the prohibition against hiring excluded individuals or entities and the fines and penalties involved when an excluded individual or entity is hired or contracted.

Remittance Advice Corner

The following is a compilation of messages that were recently transmitted to providers through Remittance Advices (RA):

Attention Professional Services Providers
Receiving Budget Adjustments on the 9/22/10 and 10/6/10 RAs

DHH has corrected the error that occurred for providers with budget adjustments from the 9/22/10 RA and repayments were made on October 7th/October 8th. Detailed information appears in a notice on the Home page of the Louisiana Medicaid web site. Information concerning the recoveries from the 10/6/10 RA is also included in this notice. Please visit the web site, www.lamedicaid.com for details.

Attention Professional Services Providers
Update Regarding Claim Adjustments on the 9/22/10 and 10/16 RAs

The remaining claim adjustments for the Aug 4, 2009 and Jan 22, 2010 rate reductions were completed on either the RA of Sept 22, 2010 or Oct 6, 2010. Refer to the notices on the homepage of the Louisiana Medicaid website (www.lamedicaid.com) for details regarding the rate reductions and claim adjustments.

Providers affected by the Oct 5, 2010 RA payment/recovery error were repaid the amount recovered in error beginning on Mon, Oct 11, 2010. In an effort to ensure that no further errors occur for providers having funds recovered through their weekly RAs, DHH will not be deducting funds from the RA of October 19 and potentially not from the RA of Oct 26, 2010. This action is being taken in an effort to ensure adequate testing of the system is completed prior to re-establishing these payment plans. Continue to monitor RAs and the LA Medicaid website. The Department will, however, recover funds for any provider that has requested that their full negative balance be recovered in one RA beginning on the October 19, 2010 RA.

Any provider still interested in an alternative payment plan is STRONGLY ENCOURAGED to send an email by OCTOBER 26, 2010 to medicaidprofessionalservices@la.gov detailing your request. Please enter "Alternative Payment Plan" in the subject line. This request is being made to help minimize any future errors due to the sporadic influx of requests the Department is receiving.

ClaimCheck: Recycle of Modifier - 51 Denials

The recycle of claims that have been previously denied for errors related to modifier - 51 (934 and 938) is scheduled to appear on the remittance advise of October 19, 2010. The recycle will apply only to those claims denied with these errors prior to the update related to modifier - 51 that was effective with the date of processing of September 7. 2010. The small number of claims that must pend for either medical review and/or issues such as timely filing will be handled outside of this recycle. Please continue to monitor the Louisiana Medicaid website homepage at www.lamedicaid.com under the ClaimCheck icon on the website, as well as future RA messages for the latest information. For further questions related to this matter, contact Molina Provider Relations at (800) 473-2783 or (225) 924-5040.

Attention Hospital Providers: Provider Notice for Retrospective Review Process

Effective October 4, 2010 hospitals must submit documentation for retrospective reviews per the clarification posted on the Louisiana Medicaid Website. Please visit www.lamedicaid.com and click on the yellow "Acute Precert" button on the left side of the home page. This will bring you to the detailed provider notice concerning this clarification.

Influenza Immunizations for Adults

Louisiana Medicaid reminds providers that seasonal influenza immunizations are a covered service for adults. Professional Services providers may be reimbursed for the seasonal influenza vaccine and the administration of the vaccine. For detailed information, see www.lamedicaid.com following the link for Billing Information/Immunizations/Adult Immunization Policy. For the current Immunization Fee Schedule, follow the link for Fee Schedules/Immunization Fee Schedules/Adult. Contact Molina Medicaid solutions Provider Relations at (800) 473-2783 or (225) 924-5040 if you should have any questions.

Attention Professional Services Providers:
Update Regarding 9/22/10 & 10/16 Claims Adjustments - Payment Plans to Resume

Providers affected by the Oct 5, 2010 RA payment/recovery error have been repaid the amount recovered in error. In an effort to ensure adequate testing of the system prior to re-establishing the payment plans, DHH temporarily ceased deducting funds from the weekly RAs of October 19-November 9, 2010. All programming and testing is complete and recovery of funds was scheduled to resume on the RA of November 16, 2010 & spread over the number of weeks remaining in the payment plans.

Refer to the notices on the homepage of the Louisiana Medicaid website (www.lamedicaid.com) for details regarding the rate reductions & claim adjustments. General questions with regard to rate reductions and claim adjustments should be directed to Molina Provider Relations at (800) 473-2783 or (225) 924-5040. Any questions specific to individual providers' alternate payment plans or recovery of funds should be referred to the Medicaid Professional Services office at medicaidprofessionalservices@la.gov. Please enter either of these topics in the subject line.

All Greater New Orleans Community Health Connection (GNOCHC) Providers

Do not submit any GNOCHC claims to Molina until further notice. The Funding and Reimbursement Protocol for the GNOCHC program is currently under development. When the protocol is finalized, the Department of Health and Hospitals (DHH) will provide detailed guidance on when and how to submit GNOCHC claims to Molina. Until then, GNOCHC provider payments will be made directly by DHH, and any GNOCHC claims submitted to Molina will be denied with error code 202 (PROVIDER CANNOT SUBMIT THIS TYPE OF CLAIM). Please continue to monitor the Louisiana Medicaid website homepage at www.lamedicad.com as well as future RA messages for the latest information. For other questions related to this program, you may e-mail GNOCHC@la.gov.

Attention Hospital Providers:
Important Billing Information Concerning Billing Claims for Deliveries

As we have implemented new policies related to inpatient stays for deliveries, we have received hospital inquiries concerning claim denials related to diagnosis codes. We want to clarify a billing issue that has come to our attention which is causing these denials.

Please visit www.lamedicaid.com for the detailed provider notice explaining what information must be present in order for the claim to process.

Attention Hospital, Physician and Outpatient Radiology Providers

New CPT codes become effective January 1, 2011. These CPT codes will require prior authorization (PA) and are included in the Radiology Utilization Management (RUM) program. The codes are part of the diagnostic CT set and are listed below:

- 74176 Computed tomography; abdomen and pelvis; without contrast material
- 74177 Computed tomography; abdomen and pelvis; with contrast material(s)
- 74178 Computed tomography; abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions.

If PA is not obtained for these procedures per the current RUM guidelines, then the procedure will not be payable by Louisiana Medicaid. For further information regarding RUM policy and procedures, please visit www.lamedicaid.com.

Online Medicaid Provider Manual Chapters

The following Medicaid Provider Manual Chapters are available on the Louisiana Medicaid website at www.lamedicaid.com under the "Provider Manual" link.

- Administrative Claiming
- Ambulatory Surgical Centers
- American Indian 638 Clinics
- Dental
- Durable Medical Equipment
- Elderly and Disabled Adult Waiver
- Family Planning Waiver (Take Charge)
- Federally Qualified Health Centers
- Home Health
- ICF/DD
- Medical Transportation
- Mental Health Clinics
- Mental Health Rehabilitation
- Multi-Systemic Therapy
- Personal Care Services
- Pharmacy
- Psychological Behavioral Services
- Rural Health Clinics

This list will be updated periodically as other Medicaid program chapters become available online.

Review of FDA Risk Evaluation and Mitigation Strategy (REMS)

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In 2007, Congress approved the Food and Drug Administration Amendments Act (FDAAA) which gave the FDA new authority over the regulation of drugs and drug marketing requirements. A provision in this legislation was titled the Risk Evaluation and Mitigation Strategy (REMS) for medications that may be associated with higher safety risks to the public. The REMS program was designed to better ensure appropriate and safe use of medications. The FDA would now have the power to control marketing and clinical studies prior to drug approval, and to increase public awareness of drug study data.

The FDA has the authority to determine which medications (or therapeutic classes of medications) need to include a REMS. This is true not only for new medications, but also for medications that have already been FDA-approved. If a new safety warning is issued or if a serious adverse event is seen in post-marketing surveillance, a request for a REMS may be triggered by the FDA for that particular medication or therapeutic class. Post-marketing surveillance identifies problems that were not seen prior to a medication's approval, usually due to relatively small sample sizes in clinical trials. Commonly used tools to identify these problems include the Adverse Event Reporting System (AERS) and MedWatch.[2]

One element of the FDAAA allows the marketing of medications that otherwise may not have gained approval due to a known, potentially serious adverse event. In this scenario, the FDA may require that a medication include "Elements to Assure Safe Use" or ETASU.[4] Many ETASU involve health-care provider certification, meaning physicians who prescribe a high-risk medication will have to receive specialty training prior to prescribing. Once a REMS is requested by the FDA, the document must contain certain elements: product name, drug class, contact information for those responsible for the REMS policy, one or more overall goals, list of specific REMS elements, implementation system, and timetable for assessment submissions.[1]

There are several factors that determine whether a medication will require a REMS. These include: [3]

1. Size of population studied
2. Seriousness of disease
3. Expected benefit and duration of treatment
4. Any known serious adverse events
5. Any new molecular entity

Once a REMS is required by the FDA, the drug manufacturer must provide the data requested within the REMS and submit its findings to the FDA.

Currently, there are several FDA-approved REMS that drug manufacturers can use, and each one was designed to increase both patients' and practitioners' awareness of a medication's potential adverse effects. However, there are potential limitations with each of them as well. The existing REMS for medications may include:[2]

1. Medication Guides (MedGuides)
2. Informed consent
3. Mandatory lab monitoring
4. Restricted distribution
5. Specialty training
6. Specific ordering/inventory process
7. Patient registries
8. Prescription stickers

MedGuides are a common element of REMS, and may include a "Dear Doctor" letter. Though MedGuides are written for patients, some patients feel as if they are hard to understand because they sometimes contain lengthy technical information and are written at a high reading level. Also, the MedGuides may create potential burdens for the healthcare providers by increasing workload with additional paperwork. The sheer number of medications that have MedGuides can be very time consuming for the pharmacist at the time of dispensing. There are currently over 100 different medications and therapeutic classes of medications that require MedGuides at the time of dispensing.[2] Mandatory lab monitoring is used for certain medications such as clozapine that can cause serious adverse events, which can be prevented by discontinuing the medication at the first sign of altered lab values. Both specialty training and restricted distribution pose their own problems, most noticeably in rural areas, where access to certain medications may be limited and care for the patient may be delayed. For example, a patient on a medication that can be prescribed only by a physician who has completed training on that medication is admitted to a rural hospital; the facility may not have an approved physician to administer that medication and the patient may go days without receiving it.

REMS for opioid analgesics were set to be reviewed by the FDA in October 2010; however, a report in *Medscape Medical News* stated that the FDA had decided to delay the review until 2011.[5] The opioid REMS would stand to dramatically change the prescribing of this class of medications which could have a major impact on both physicians and patients. Two major issues were at the forefront of the FDA's decision for the delay: the question of whether or not to include all opiate formulations rather than the original FDA recommendation of only the extended-release or long-acting opiates, and the debate concerning the need for increased training of safe and effective opioid prescribing for physicians. The first became an issue when the FDA advisory committee proposed that the REMS cover all opiates, but the assumption was that physicians would be less likely to prescribe short-acting medications for acute pain if there was an increase in requirements to do so.[5] The second issue arose after debate over whether increased physician education regarding the prescribing of opiates should be voluntary or mandatory. If this became an addition to the Drug Enforcement Agency opiate prescribing requirements, it would not only have to be approved by Congress, but the committee's fear was that many physicians would choose not to prescribe opiates to avoid the inconvenience of the additional requirements.[5]

REMS is a post-marketing surveillance process created by the FDA to help ensure the safety of medications and to help improve communication between pharmaceutical companies, prescribers, and patients. The goal is to help improve patient safety and minimize potential drug-related issues. Hopefully, the collaborative efforts of the FDA and healthcare providers will maximize the benefit of REMS and minimize the potential pitfalls of a medication's adverse effects.

Table 1: Examples of Common Medications with Approved REMS*

Drug Name	Date REMS Approved	REMS Components (All REMS include timetable for assessment)
Actos (pioglitazone hydrochloride) Tablets	9/9/2009	Medication guide
Advair Diskus (fluticasone propionate and salmeterol xinafoate inhalation powder)	4/30/2008	Medication guide
Aranesp (darbepoetin alfa) Injection	2/16/2010	Medication guide, communication, elements to assure safe use, implementation system
Byetta (exanatide) Injection	10/30/2009	Medication guide, communication plan
Chantix (varenicline) Tablets	10/19/2009; modified 4/22/2010	Medication guide
Effient (prasugrel) Tablets	7/10/2009; 4/16/2010	Medication guide, communication plan
Levaquin (levofloxacin) Tablets, Injection, and Oral Solution	4/27/2009	Medication guide
Reglan (metoclopramide hydrochloride) Tablets	9/4/2009	Medication guide
Tracleer (bosentan) Tablets	8/7/2009; modified 2/19/2010	Medication guide, elements to assure safe use, implementation system
Victoza (liraglutide) Injection	1/25/2010	Medication guide, communication plan

*For a complete list, please refer to the FDA website:
www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111350.htm

References

1. FDA. Guidance for industry. Format and content of proposed risk evaluation and mitigation strategies (REMS), REMS assessments, and proposed REMS modifications. September 2009. Available at http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/UCM184128.pdf. Accessed September 20th, 2010.

2. Lofton, Judy Crespi. White Paper on Designing a Risk Evaluation and Mitigation Strategies (REMS) System to Optimize the Balance of Patient Access, Medication Safety, and Impact on the Health Care System. J Am Pharm Assoc. 2009; 49(6): 729-743.

3. Wechsler, Jill. FDAAA empowers FDA to have greater control over drug safety. Formulary. Dec.1, 2007

4. Olin, Jacqueline L., Ziglar, Susan. Legislation update: Risk Evaluation and mitigation strategies. Drug Topics. August, 2010: pg26-35.

5. http://updates.pain-topics.org/2010/08/us-fda-delays-opioid-rems-until-2011.html

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Provider Enrollment	**(225) 216-6370**
Prior Authorization	
Home Health/EPSDT - PCS	**1-800-807-1320**
Dental	**1-866-263-6534** **1-504-941-8206**
DME & All Other	**1-800-488-6334** **(225) 928-5263**
Hospital Pre-Certification	**1-800-877-0666**
Provider Relations	**1-800-473-2783** **(225) 924-5040**
REVS Line	**1-800-776-6323** **(225) 216-REVS (7387)**
Point of Sale Help Desk	**1-800-648-0790** **(225) 216-6381**
General Medicaid Eligibility Hotline	**1-888-342-6207**
LaCHIP Enrollee/Applicant Hotline	**1-877-252-2447**
MMIS/Claims Processing/ Resolution Unit	**(225) 342-3855**
MMIS/Recipient Retroactive Reimbursement	**(225) 342-1739** **1-866-640-3905**
Medicare Savings Program Medicaid Purchase Hotline	**1-888-544-7996**
KIDMED & CommunityCARE ACS For Hearing Impaired	**1-800-259-4444** **1-877-544-9544**
Pharmacy Hotline	**1-800-437-9101**
Medicaid Fraud Hotline	**1-800-488-2917**