Louisiana Medicaid | Provider UPDATE

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Influenza Fast Facts

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University of Louisiana at Monroe
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- CDC estimates that, from October 1, 2018 through January 19, 2019, there have been:
  - 9.8 to 11.4 million flu illnesses
  - 4.6 to 5.4 million flu medical visits
  - 113,000 to 136,000 flu hospitalizations
- The 2018 – 2019 season is underway and flu activity is nationally elevated.
- According to the CDC, as of mid-November 2018, 44.9 percent of adults and 45.6 percent of children had received the flu vaccine.
- Although these numbers are higher for both children and adults from this time last year, there are still many people that remain unvaccinated.
- Every year, an estimated 5 to 20 percent of the population in the United States will get the flu.
- Over the course of last year's flu season, more than 900,000 people were hospitalized and more than 80,000 people died (180 were children) from the flu and its complications.
- Because of the severity of last year's flu season, the CDC recommends that physicians do the following for patients 6 months of age and older:
  - Ask about the vaccination status of the patient at each visit
  - Make a strong recommendation to get vaccinated
  - Ensure that the patient knows the potential consequences of not protecting themselves

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Is it too late in the influenza season to be vaccinated?

The answer is no! Vaccination can still be beneficial as long as flu viruses are circulating. Although the CDC recommends getting the flu vaccine by the end of October, getting vaccinated later can still be beneficial, and the influenza vaccination should continue to be offered throughout flu season, even into January or later. Flu is unpredictable, and seasons can vary. Seasonal flu disease usually peaks between December and March in most years, but disease can occur as late as May.

CDC Influenza Surveillance in the U.S.

The Influenza Division of the Centers for Disease Prevention and Control (CDC) Epidemiology and Prevention Branch collects, compiles and analyzes information on influenza activity year-round in the United States and produces a weekly influenza surveillance report. The U.S. influenza surveillance system is a collaborative effort between the CDC and its many partners in state, local, and territorial health departments, public health and clinical laboratories, vital statistics offices, healthcare provider offices, clinics, and emergency departments. Information in five categories is collected from eight different data sources that allows the CDC to:

- Find out when and where influenza activity is occurring
- Track influenza-related illness
- Determine what influenza viruses are circulating
- Detect changes in influenza viruses
- Measure the impact influenza is having on hospitalizations and deaths

This information is compiled from several sources including virologic surveillance, outpatient illness surveillance, hospitalization surveillance, mortality surveillance, and state health departments' reports of the geographic spread of influenza.

Together, the five categories of influenza surveillance are designed to provide a national picture of influenza activity. It is important to maintain a comprehensive system for influenza surveillance for several reasons:

- Influenza viruses are constantly changing and thus ongoing data collection and characterization of the viruses are required.
- Influenza viruses can rapidly undergo changes leading to pandemics of influenza; surveillance of viruses will detect these changes.
- Vaccines must be administered annually and are updated regularly based on surveillance findings.
- Treatment for influenza is guided by laboratory surveillance for antiviral resistance.
- National responses to emerging pandemic strains are triggered by surveillance data.
- Varying segments of the population are affected by influenza and may require targeted interventions. These groups are determined in part through influenza surveillance and targeted research studies.

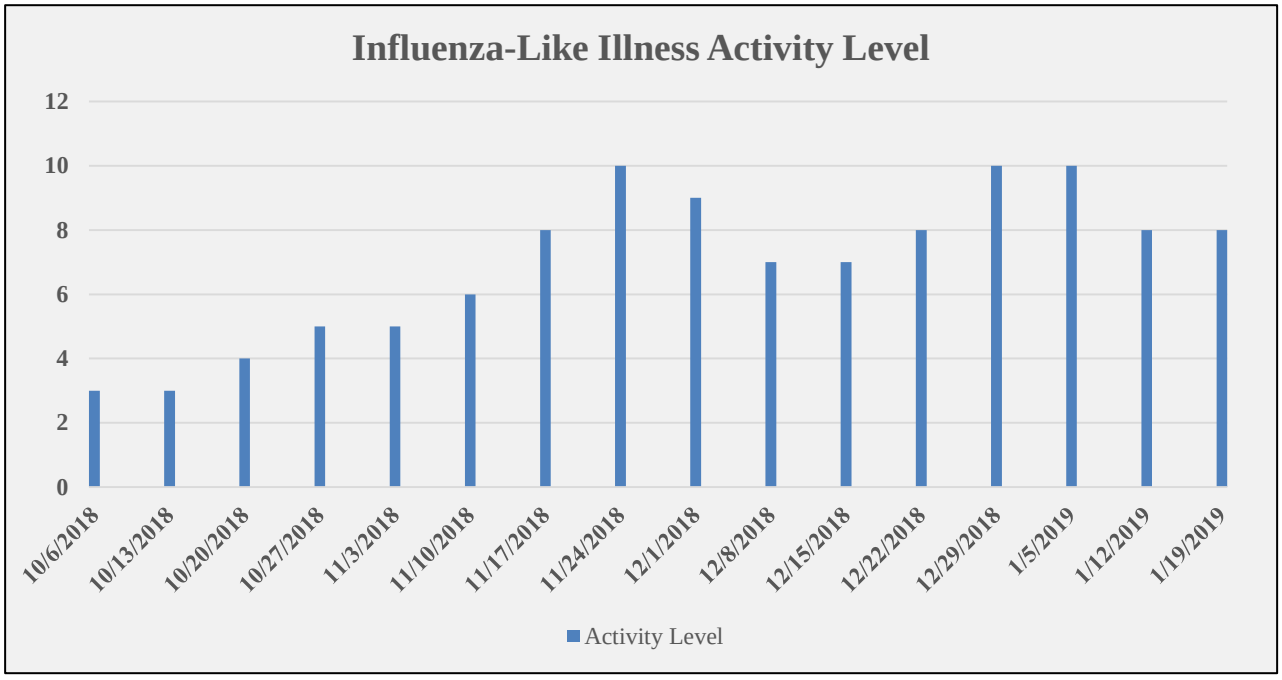
It is important to remember the following about influenza surveillance in the United States:

- All influenza activity reporting by public health partners and health-care providers is voluntary.
- The reported information answers the questions of where, when, and what influenza viruses are circulating. It can be used to determine if influenza activity is increasing or decreasing, but does not directly report the number of influenza illnesses.
- The system consists of eight complementary surveillance components in five categories. These components include reports from laboratories, outpatient healthcare providers, the National Center for Health Statistics, and all state, local and territorial health departments.

U.S. Outpatient Influenza-Like Illness Surveillance Network (ILINet) and Louisiana ILI Activity

Information on outpatient visits to healthcare providers for influenza-like illness is collected through the U.S. Outpatient Influenza-Like Illness Surveillance Network (ILINet). ILINet consists of more than 3,500 enrolled outpatient healthcare providers in all 50 states, Puerto Rico, the District of Columbia and the U.S. Virgin Islands reporting more than 47 million patient visits each year. Each week, approximately 2,200 outpatient healthcare providers around the country report data to the CDC on the total number of patients seen for any reason and the number of those patients with influenza-like illness (ILI) by age group (0-4 years, 5-24 years, 25-49 years, 50-64 years, and ≥65 years). For this system, ILI is defined as fever (temperature of 100°F [37.8°C] or greater) and a cough and/or a sore throat without a known cause other than influenza. Sites with electronic health records use an equivalent definition as determined by public health authorities.

Data collected in ILINet are used to produce a measure of ILI activity by state. Activity levels are based on the percent of outpatient visits in a state attributed to ILI and are compared to the average percent of ILI visits that occur during weeks with little or no influenza virus circulation. Activity levels are categorized as follows: minimal (levels 1 – 3), low (levels 4 – 5), moderate (levels 6 – 7), and high (levels 8 – 10). Minimal activity levels correspond to ILI activity from outpatient clinics being below or slightly above the average, while high activity levels correspond to ILI activity from outpatient clinics being much higher than average. Louisiana's ILI activity levels, as of the weekend of January 12, 2019, as reported by the CDC, are represented in the graph below:



Reference: www.cdc.gov

Attention Behavioral Health Services Providers

Louisiana Medicaid has implemented changes required by Senate Bill No. 564 for behavioral health services providers (BHSPs) of Community Psychiatric Support and Treatment (CPST) or Psychosocial Rehabilitation (PSR) Services. Changes include CPST and PSR requirements related to:

- Member Choice Forms;
- Staff educational requirements;
- Staffing;
- Supervision;
- Accreditation;
- Credentialing; and
- Claims payment.

BHSPs must meet all qualifications and requirements in statute, rule and the Medicaid Behavioral Health Services Provider Manual prior to rendering services.

Providers can review Informational Bulletin 18-14 for additional details. Updates to the provider manual inclusive of effective dates are forthcoming and will be found at www.lamedicaid.com under the Provider Manuals link within the Behavioral Health Services Manual.

Questions related to managed care should be directed to the appropriate Managed Care Organization (MCO).

Pharmacy Facts can also be found online at: http://ldh.la.gov/index.cfm/page/3036.

December 7, 2018 Revised: 1.10.2019

Medicaid plans for 2019 single preferred drug list, dispensing fee and ingredient cost changes
Louisiana Medicaid has established a May 2019 timeline for implementation of a single preferred drug list (PDL) across all managed care organizations (MCOs) and Medicaid fee-for-service. To address concerns expressed in recent stakeholder discussions, Medicaid will also make changes to the pharmacy program's dispensing fee and ingredient cost methodology at the same time.

"Medicaid will use data from our most recent Cost of Dispensing (COD) survey to establish a uniform dispensing fee for all pharmacy providers," Jen Steele, Medicaid director, said. "We are committed to seeking approval from the Centers for Medicare and Medicaid Services (CMS) for an increase in the dispensing fee amount from $10.41 to $10.99 for both chain and independent pharmacies."

Medicaid pharmacy reimbursement for ingredient cost is currently determined using the average acquisition cost (AAC), which relies on localized invoices from Louisiana-based prescribers. Stakeholders expressed an interest in shifting to the national average drug acquisition cost (NADAC), and Medicaid has committed to also pursuing CMS approval for this change.

Although the dispensing fee and NADAC changes are only applicable to fee-for-service Medicaid, MCOs are mandated (through legislation) to reimburse local pharmacies at the fee-for-service rate.

Input from a wide range of stakeholders – including prescribers, independent and chain pharmacies, and others – was considered when drafting the program changes. "We made every effort to accommodate everyone's interests and concerns," Steele said, "and we appreciate the willingness of everyone to come to the table and compromise." Additional background on the single PDL discussions and the COD survey can be found in previous editions of Pharmacy Facts.

ATTENTION PROVIDERS/SUBMITTERS
Medicare and Medicaid Advantage Filing Guidelines

A recent review of claims for either dual eligible Medicare Medicaid recipients and/or QMB only recipients revealed many claim filing errors. To help reduce the number of denied claims or rejected claim files, you should follow the guidelines listed below:

- Some claims for dual eligible recipients are being submitted electronically as fee for service Medicaid claims. Submitters must not add claims with Medicare Coverage indicated into an 837P file with a file extension of **.PHY.**

- Claims for dual eligible recipients for coinsurance/deductible consideration should not be sent to DXC **UNLESS** the claim has failed to crossover from Medicare. If that is the situation, then the claim **MUST** be filed HARDCOPY with Medicare EOBs and not submitted electronically. Same guidelines apply when adjusting Medicare claims.

- Claims for dual eligible recipients with Medicare Advantage coverage can be filed electronically; however, there are special requirements for the layout of these files. Providers must work with their clearinghouse or submitter to ensure that the correct procedures are being followed. Submitters should contact DXC EDI and arrange for testing prior to sending such claims to Production. Refer to articles on lamedicaid.com dated 1/31/18 and 4/24/18 for additional details. The 837 Companion Guides have Medicare Advantage claim examples included.

- Claims for dual eligible recipients with **denials** for certain services not covered under traditional Medicare Part B coverage may be filed electronically as fee for service claims. The Medicare denial reason(s) must meet criteria established by the Louisiana Department of Health (LDH) as there are some exceptions. Refer to previous articles on lamedicaid.com dated 5/16/17 and 1/31/18 for details on how to file this claim type.

Eligibility and Enrollment System Provider Bulletins

Louisiana Medicaid is publishing bi-weekly provider bulletins to address provider questions and concerns around the new eligibility and enrollment system. The information in these bulletins covers a wide range of provider issues and provider types. This and other news can be found on the web site dedicated to the new system, found here: http://ldh.la.gov/index.cfm/page/3497.

If there are topics you feel need to be covered in these public communications, please let us know by sending an email to Healthy@la.gov.

Online Medicaid Provider Manual Chapter Revisions as of January 2019		
Manual Chapter	**Section(s)**	**Date of Revision(s)**
Applied Behavior Analysis	4.1 Covered Services	01/16/19
Adult Day Health Care	9.1 Covered Services 9.2 Recipient Requirements 9.4 Service Access and Authorization 9.5 Provider Requirements 9.7 Reimbursement Appendix B Forms/Links	01/16/19
Behavioral Health Services	2.3 Outpatient Services – Rehabilitation Services for Children, Adolescents and Adults	01/01/19
Community Choice Waiver	7.1 Covered Services 7.2 Self-Direction Option 7.7 Record Keeping 7.8 Reimbursement 7.9 Program Oversight and Review Appendix E Glossary	01/16/19
Durable Medical Equipment	Table of Contents 18.2 – Specific Coverage Criteria	01/01/19
Federally Qualified Health Centers	22.1 Covered Services 22.4 Reimbursement	01/01/19 01/18/19
Professional Services	Table of Contents 5.1 Genetic Testing	01/01/19
Residential Options Waiver	Appendix E Billing Codes	01/1719 01/23/19
Rural Health Clinics	40.1 Covered Services 40.4 Reimbursement	01/01/19 01/18/19

Archived Online Medicaid Provider Manual Chapter Revisions as of January 2019		
Manual Chapter	**Section(s)**	**Date of Omission(s)**
Applied Behavior Analysis	4.1 Covered Services	01/16/19
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Remittance Advice Corner

Attention Louisiana Medicaid Providers

Effective January 1, 2019, Fee for Service (FFS) Medicaid and Managed Care Organizations (MCOs) will implement a diagnosis code exemption for sickle cell crisis for opioid prescriptions. Please refer to www.lamedicaid.com for more information.

Attention Louisiana Fee for Service (FFS) Medicaid Providers

On January 9, 2019, Fee for Service (FFS) Medicaid and Managed Care Organizations (MCOs) implemented diagnosis code requirements, maximum daily dose, and quantity limits at Point of Sale (POS) for aripiprazole (Aristada®) and risperidone (Perseris®). Please refer to www.lamedicaid.com for more information.

Attention Louisiana Fee for Service (FFS) Medicaid Providers

On January 9, 2019, Fee for Service (FFS) Medicaid and Managed Care Organizations (MCOs) implemented Point of Sale (POS) edits for pimavanserin (Nuplazid®). Please refer to www.lamedicaid.com for more information.

Attention Louisiana Fee for Service (FFS) Medicaid Providers

On December 27, 2018, Fee for Service (FFS) Medicaid implemented clinical pre-authorization requirements at Point of Sale (POS) for Growth Hormones, Cytokine and Cell-Adhesion (CAM) Molecule Antagonists, Lomitapide (Juxtapid®), Mipomersen (Kynamro®), Alirocumab (Praluent®), and Evolocumab (Repatha®). Please refer to www.lamedicaid.com for more information.

Attention FQHC and RHC Providers

Please be advised that Louisiana Department of Health (LDH) is retracting implementation of a separate payment for screening and diagnostic mammography for FQHC and RHC providers on 1/1/2019 as previously announced.

The Centers for Medicare and Medicaid (CMS) informed LDH on 1/15/19 that the request for the separate reimbursement for screening and diagnostic mammography for FQHC and RHC providers was not approved.

Please contact Irma Gauthier at Irma.Gauthier2@la.gov with questions regarding this message.

Attention Obstetricians and Gynecologists

Louisiana Medicaid has been in communication with the Office of Population Affairs (OPA) concerning the upcoming expiration date (January 31, 2019) on the current Sterilization Consent Form (HHS 687). OPA is in the process of renewing the form, but will extend the expiration date of the current form one month at a time until final approval on the update form is received.

DXC Technologies will continue to accept the most current form until OPA publishes an updated form and expiration date. Providers are encouraged to check the OPA site directly for updates.

Once the update occurs, an RA message will be published letting providers know how long the prior form will be accepted by DXC Technologies.

Questions regarding this message and fee for service claims should be directed to DXC Technology Provider Relations at (800) 473-2783 or (225) 924-5040. Questions regarding managed care claims should be directed to the appropriate Managed Care Organization.

For Information or Assistance, Call Us!

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
MMIS Claims Processing Resolution Unit	(225) 342-3855
MMIS/Recipient Retroactive Reimbursement	(225) 342-1739 1-866-640-3905
Medicare Savings Program and Medicaid Purchase Hotline	1-888-544-7996
For Hearing Impaired	1-877-544-9544
Pharmacy Hotline	1-800-437-9101
Medicaid Fraud Hotline	1-800-488-2917