Louisiana Medicaid | Provider UPDATE

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Insomnia Management

Gregory W. Smith, Pharm D.
The University of Louisiana at Monroe College of Pharmacy

Introduction

Insomnia is described as impaired daytime function due to difficulty falling asleep, difficulty staying asleep, or waking up early in the morning without the ability to return to sleep. This occurs despite adequate opportunity and circumstances for sleep. Though frequently secondary to a medical condition, psychiatric illness, sleep disorder, or medication, insomnia can often occur in the absence of coexisting conditions as an independent disorder.

Key Points for Management of Insomnia

- Currently revised diagnostic definitions of insomnia disorder require the identification of sleep symptoms accompanied by daytime dysfunction or distress.
- All insomnia patients should be evaluated and treated for any medical or psychiatric illnesses, substance abuse, or other sleep disorders that may precipitate or worsen insomnia.
- The American College of Physicians recommends that all adult patients receive cognitive behavioral therapy for insomnia (CBT-I) as the initial treatment for chronic insomnia disorder.
- Patients with insomnia may benefit from CBT-I as initial therapy only, rather than medication; medication may then be added for persistent symptoms.
- Combination therapy may involve initially prescribing both CBT-I and a medication (usually for six to eight weeks); the medication can then be tapered off while continuing CBT-I.
- The Agency for Healthcare Research and Quality (AHRQ) reported that "eszopiclone, zolpidem, and suvorexant may improve short-term global and sleep outcomes for adults with insomnia disorder, but the comparative effectiveness and long-term efficacy of pharmacotherapies for insomnia are not known."
- Initiation of therapy may be warranted with only an initial evaluation, if the patient presents with an obvious acute stress inducer, such as grief.
- Hypnotics should only be used short term, with therapy customized to the patient's individual circumstances in terms of frequency and duration.
- For sleep-onset insomnia, a short-acting agent rather than a long-acting agent is suggested.
- For sleep maintenance, a long-acting agent rather than a short-acting agent is suggested; sublingual and very short-acting agents are indicated specifically for middle of the night awakenings.
- The use of alcohol as a sleep aid should be discouraged, as it can promote sleep disturbances, upper airway instability and sleep apnea.
- Short-term therapy with benzodiazepines is supported by clinical studies; however, the long-term use of this class of drugs may lead to dependence and tolerance.
- Practice safe prescribing and schedule follow-ups to evaluate therapy efficacy, adverse effects, medication continuation, and non-pharmacologic options.
- Instruct patients on the proper timing of the medication, considering desired sleep onset, duration of effect to reduce the risk of next-day impaired alertness, memory, coordination and driving.

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Prevalence

- Prevalence estimates vary according to the definition of insomnia used:
  - 3.9% based on International Classification of Diseases - Tenth Revision (ICD-10) criteria
  - 14.7% based on International Classification of Sleep Disorders - Second Edition (ICSD-2) criteria
  - 22.1% based on Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition text revision (DSM-IV) criteria
- Approximately twice as many women suffer from insomnia as men, with increased prevalence among the aged.
- Short-term insomnia occasionally affects 30 to 50% of the population.
- The estimated prevalence of chronic insomnia disorder in industrialized nations is at least 5% to 10%, and is significantly higher in medically and psychiatrically ill populations, often exceeding 30%.

Impact

In addition to the obvious physical and mental impact that a chronic sleep disorder can have on a patient, insomnia has a negative impact on the individual's quality of life. Patients with severe insomnia assess themselves as having a quality of life similar to patients who suffer with congestive heart failure or depression.

People with severe insomnia:

- Report more medical problems
- Have more physician office visits
- Are hospitalized twice as often
- Have a higher rate of absenteeism from work
- Miss work twice as often as good sleepers
- Have more work-related accidents

The combined economic impact of insomnia including job absenteeism, decreased productivity, accidental property damage and higher healthcare cost is estimated to be greater than $100 billion annually.

A review of the cost effectiveness of both pharmacological and behavioral treatments for insomnia reported that the cost of treating insomnia is less than the cost of not treating the disorder; treatments were generally found to be cost-effective using commonly employed standards, with treatment costs being recouped within 6 to 12 months.

Comorbid Conditions

When coexisting conditions exist, insomnia may persist despite successful treatment of the coexisting condition. Therapy directed at both the insomnia and the comorbidity may be necessary. Given that insomnia can precipitate, worsen, or prolong comorbid conditions, treatment of insomnia may improve comorbidities.

For severe or chronic insomnia, a thorough evaluation is necessary to determine coexisting medical, neurological or psychiatric problems. Chronic insomnia is more prevalent in patients with one or more medical or psychological disorders.

- There is a well-established bidirectional relationship between insomnia and depression.
- Insomnia may be the first sign that a major depressive episode is approaching and among the last of symptoms to resolve after the patient's depression has been treated.
- Insomnia may precede an increased risk of subsequent depressive episodes and suicidal ideations.

Insomnia has been linked to psychiatric illnesses other than depression that cause or worsen insomnia, including:

- Anxiety
- Nicotine use
- Mood disorders
- Substance abuse
- Alcohol dependence relapse
- Post-traumatic stress

Other medical conditions associated with chronic insomnia:

- Hypertension
- Diabetes mellitus
- Recurrent cardiac events
- Circadian rhythm disorders
- Heart failure
- Restless legs syndrome
- Chronic pain
- Obesity
- Pulmonary disease
- Cancer
- Sleep apnea
- Periodic limb movements of sleep

Drug-Induced Insomnia

Insomnia is a potential adverse effect of many medications, such as central nervous system stimulants, central nervous system depressants, bronchodilators, respiratory stimulants, antidepressants, beta antagonists, calcium channel blockers, and glucocorticoids. Other substances that contribute to insomnia include alcohol, tobacco, OTC medications, and illicit drugs. Insomnia may be a predictor of substance abuse.

Evaluation of Insomnia

A diagnosis of insomnia can be made when all three of the following criteria are met:

- Difficulty initiating sleep, difficulty maintaining sleep, or waking up too early
- Sleep difficulty occurs despite adequate opportunity and circumstances for sleep
- Sleep deficiency produces impairment in daytime function

In addition to complaints of insomnia despite adequate opportunity and circumstances for quality sleep, the patient may report the following compromised daytime function:

- Fatigue/malaise
- Social/vocational/educational dysfunction
- Daytime sleepiness
- Increased errors/accidents
- Persistent worry about sleep
- Poor concentration/attention
- Mood disturbance
- Reduced motivation/energy
- Hyperactivity/impulsivity/aggression

A differential diagnosis may be needed as insomnia is often confused with other disorders, such as short duration sleep, circadian rhythm disorder, chronic sleep restriction, and sleep-disruptive environmental circumstances. In addition to gathering patient history and examining the patient for coexisting medical or psychiatric illness, further examination may include:

- Obtaining a sleep history
- Interviewing a partner or family member about the sleep habits of the patient, their daily function, history of substance use and problems with snoring or apnea
- Conducting a physical exam, which should include a neurologic evaluation

Other methods of evaluating insomnia include:

- Sleep log to get an accurate picture of the patient's sleep habits, moods and daytime function
- Polysomnography for suspected apnea or periodic limb movement disorder; also used when behavioral or pharmacological therapies are not successful
- Actigraphy which uses an activity monitor and is useful in evaluation of sleep patterns
- Multiple sleep latency tests only for suspected narcolepsy
- Psychiatric tests, such as the Beck Depression Scale and the State-Trait Anxiety Inventory, if psychiatric illness is suspected
- Other instruments, such as the Insomnia Severity Index and the Pittsburgh Sleep Quality Index, which are used for measuring global outcomes
- Neuroimaging for suspected lesions

Psychological/Behavioral Interventions

Treatment for insomnia should begin with nonpharmacologic therapy which includes basic behavioral counseling about good sleep hygiene, stimulus control, relaxation techniques and sleep restriction therapy.

CBT-I	This approach involves elements of sleep restriction, stimulus control, sleep hygiene education, and cognitive therapy and may include relaxation techniques. American College of Physicians recommends that all adult patients receive cognitive behavioral therapy for insomnia (CBT-I) as the initial treatment for chronic insomnia disorder. An AHRQ systematic review reported that the strongest evidence for the efficacy were from the use of CBT-I.
Sleep Hygiene	See the attached patient brochure for actions that are likely to improve and maintain good sleep.
Stimulus Control Therapy	Patients may associate their sleeping environment with the fear of not sleeping, rather the anticipation of good sleep. Therefore, patients should work to disrupt this association. Examples include not going to bed until sleepy, avoid stimulating activities upon waking during the night, and setting an alarm to wake up at the same time every day.
Relaxation	There are two common techniques implemented before each sleep period: Progressive relaxations: learning to relax one muscle at a time until the whole body is relaxed Relaxation response: relaxed abdominal breathing pattern while maintaining a neutral mental focus on a peaceful word or image
Sleep Restriction Therapy	Limiting the amount of time allowed in bed (including naps and other sleep outside of bed) helps to consolidate sleep and improves sleep efficiency.

Pharmacologic Treatments

Patient Self-Medication:

Patients have a tendency to self-medicate**.** Nonprescription sleep aids are popular for self-treatment of insomnia. The choices for self-treatment for insomnia include alcohol, OTC non-herbal sleep aids, and melatonin.

Alcohol should not be used to treat insomnia, due to its potential for abuse. Alcohol reduces sleep-onset latency, but it increases sleep disruptions after onset and suppresses rapid eye movement (REM) sleep. Opiates may be helpful for certain patients with insomnia associated with pain; however, the quality of sleep produced is fragmented and of poor quality.

Safe Prescribing Practices for Insomnia Medications:

- Prescribe lowest effective dose; avoid exceeding maximum recommended dose.
- Warn patients to avoid combining insomnia medications with alcohol or other sedatives.
- Use caution with older patients due to fall risks and renal/liver dysfunction.
- With comorbid depression, assess for suicidal ideation before prescribing.
- Instruct patients on the proper timing of the medication, considering desired sleep onset, duration of effect to reduce the risk of next-day impaired alertness, memory, coordination and driving.
- Regularly evaluate the patient for therapy efficacy, adverse effects, continuation and non-pharmacologic options.

Choice of Agent:

Common adverse effects for many insomnia medications include residual daytime sedation, drowsiness, dizziness, lightheadedness, cognitive impairment, motor incoordination, respiratory suppression and dependence. Due to respiratory suppression, both BZDs and non-BZDs can potentially worsen obstructive sleep apnea. The benefits of pharmacologic treatment for insomnia should be weighed against the risks of adverse effects, in addition to physical and psychological addiction with long-term use. Risks may be increased in certain clinical circumstances, such as pregnancy, alcohol consumption, renal or hepatic disease, pulmonary disease, sleep apnea, nighttime decision making, and advanced age (especially those older than 75 years). Older adults have a higher risk of adverse effects from sedative hypnotic drugs, including excessive sedation, cognitive impairment, delirium, night wandering, agitation, postoperative confusion, balance difficulties, and impaired daily activity performance. There is an increased risk of falls with severe consequences such as traumatic brain injury and hip fracture with hypnotic use in older patients, particularly with zolpidem.

When selecting among various sedative-hypnotic medications, choose on the basis of the type of insomnia (i.e., sleep onset or sleep maintenance) and the duration of effect. For sleep-onset insomnia, a short-acting medication is a reasonable choice. For sleep-maintenance insomnia, a longer-acting medication is preferable for an initial trial therapy. Refer to the American Academy of Sleep Medicine clinical practice guidelines for specific agent recommendations and strength of evidence.

FDA-Approved Insomnia Medications

Drug	Duration of Action	Insomnia Indication
Benzodiazepines:		
Estazolam	Intermediate	Short-term management of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings, and/or early morning awakenings
Flurazepam	Long	Insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings, and/or early morning awakening
Quazepam	Long	Insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings, and/or early morning awakening
Temazepam	Intermediate	Short-term treatment of insomnia (generally 7 to 10 days)
Triazolam	Short	Short-term treatment of insomnia (generally 7 to10 days)

Nonbenzodiazepines:		
Eszopiclone	Intermediate	Sleep Onset and Sleep Maintenance [a]
Zolpidem	Short	Sleep Onset and Sleep Maintenance [b,c,d]
Zaleplon	Ultrashort	Sleep Onset [b,e]
Melatonin-receptor agonist:		
Ramelteon	Short	Sleep Onset
Orexin-receptor antagonist:		
Suvorexant	Intermediate	Sleep Onset and/or Maintenance
Antidepressants:		
Silenor® (doxepin)	Long	Sleep Maintenance

[a] FDA approved for treatment of chronic insomnia.
[b] FDA approved for short-term insomnia management.
[c] For sleep-maintenance insomnia, Zolpidem controlled-release formulation is recommended.
[d] For sleep-maintenance insomnia, administered the sublingual form upon waking during the night, if at least four hours of time in bed remain after administration.
[e] For sleep-maintenance insomnia, administered upon waking during the night, if at least four hours of time in bed remain after administration.

Benzodiazepines (BZDs)

- FDA-approved BZDs for insomnia include: estazolam, flurazepam, quazepam, temazepam and triazolam. These are safe and effective in improving both sleep onset and sleep maintenance with short-term insomnia when used at clinically recommended doses.
- The long-term use of this class of drugs may lead to tolerance and dependence.
- Common undesirable effects include: residual daytime sedation, anterograde amnesia, cognitive impairment, motor impairment, rebound insomnia and withdrawal symptoms upon discontinuation.
- Most adverse effects are dose dependent; therefore, the lowest effective dose should be used for the shortest period of time, as determined by clinical need.
- Avoid long-acting BZDs in older adults due to increased risk of adverse effects; there is an increased risk of falls with severe consequences such as traumatic brain injury and hip fracture with hypnotic use in older patients.

Non-Benzodiazepines

- FDA-approved for insomnia in this class include: zolpidem (available in extended-release and sublingual forms), zaleplon, and eszopiclone.
- Non-BZDs decrease sleep latency and the number of awakenings, while improving sleep duration and quality.
- In 2013, the FDA published a safety communication that recommended lower zolpidem dosing and revised product labeling to include a warning to avoid driving the day after taking zolpidem extended-release.

Melatonin-Receptor Agonists

- Ramelteon is currently the only melatonin-receptor agonist approved by the FDA for sleep-onset insomnia.
- The advantage of this medication is that it has very low abuse and dependence potential.
- Ramelteon should be used with caution in patients with hepatic insufficiency, due to liver metabolism.
- Adverse reactions are generally milder than the BZD and non-BZD medications, with the most common being somnolence as expected.

Orexin Receptor Antagonist

- Suvorexant is currently the only medication approved by the FDA for this new drug class, and is indicated for sleep onset and/or sleep maintenance.
- Clearance is decreased in obese female patients, which has shown to result in a 46% exposure increase relative to non-obese females.
- Common adverse effects include daytime somnolence and headache. Next day driving may be impaired as with other hypnotics.
- Suvorexant should be used with caution in vulnerable patients such as those with COPD or obstructive sleep apnea.

Antidepressants

Silenor® (doxepin) is the only antidepressant approved for the treatment of insomnia.

Antihistamines

OTC antihistamines such as diphenhydramine and doxylamine should not be recommended routinely for insomnia because they:

- Are minimally effective for sleep induction
- May reduce sleep quality
- May cause residual drowsiness

CBT-I/Pharmacologic Combination Therapy

Combination therapy involves initially prescribing both CBT-I and a medication (usually for six to eight weeks), then tapering the medication off or to an as-needed schedule while continuing CBT-I.

Evidence indicates that CBT-I alone, drug therapy alone, and combination therapy all improve measures of insomnia within weeks of initiating the therapy. Continuing CBT-I alone after the completion of initial pharmacologic therapy appears to be best for maintaining improvement long-term. Continuing CBT-I also seems to increase the likelihood that the medication can eventually be tapered. ACP recommends "*clinicians use a shared decision-making approach, including a discussion of the benefits, harms, and costs of short-term use of medications, to decide whether to add pharmacological therapy in adults with chronic insomnia disorder in whom cognitive behavioral therapy for insomnia (CBT-I) alone was unsuccessful.*"

Conclusion

Insomnia is a major public health concern that affects the lives of millions of people. Healthcare professionals should understand that a patient's insomnia may be related to a variety of causes or contributors including physical or psychiatric problems. An accurate diagnosis is essential to guide an individualized treatment strategy, which may include a variety of behavioral and pharmacologic approaches.

References available upon request.

PATIENT EDUCATION HANDOUT

INSOMNIA DISORDER: WHAT TO DO WHEN YOU CAN'T SLEEP

What is insomnia disorder?

You may have insomnia if you have trouble sleeping at least 3 nights each week for at least 3 months.
You may have trouble falling asleep or staying asleep. You may:

- Lay awake for a long time before falling asleep
- Wake up often and have trouble getting back to sleep
- Stay awake for most of the night
- Wake up too early in the morning

Insomnia can cause other problems during your daily life. You may:

- Feel tired or sleepy during the day
- Feel irritable, anxious, or depressed
- Worry about not being able to sleep
- Not have enough energy
- Forget things often
- Have trouble concentrating

How is insomnia disorder diagnosed?

Your doctor will ask you about your sleep problems and how long they have lasted.
Your doctor may ask you:

- What you usually do before going to bed
- If there is something causing you to feel stressed or upset
- How much caffeine you have each day
- What other health problems you have
- How often you drink alcohol
- If you snore
- If you smoke
- If you exercise regularly
- What medicines you take
- If you have any chronic pain

Your doctor may ask you to keep a daily log of your sleep for a week or two.

How is insomnia disorder treated?

To improve your sleep, your doctor may suggest that you:

- Sleep as long as necessary, then get out of bed (7 to 9 hours seems best for most people)
- Maintain a regular sleep schedule (set an alarm clock every day, even on the weekends or days off)
- Do not try to force sleep
- Avoid caffeinated beverages after noon meal
- Avoid alcohol in late afternoon/evening
- Avoid nicotine during the evening
- Decrease lighting and sound in your bedroom
- Avoid using light-emitting screens (TVs, cell phones, laptops, electronic tablets) before bedtime
- Try to solve concerns/worries before bedtime
- Regular exercise for at least 20 minutes, but no more than 4-5 hours before bedtime
- Avoid daytime naps longer than 20-30 minutes, especially late in the day

Your doctor may suggest that you go to a sleep specialist.
The first treatment your doctor or sleep specialist will likely recommend is Cognitive Behavioral Therapy for Insomnia, also called CBT-I.

- The goal of CBT-I is to help change your habits and negative thoughts about sleep.
- CBT-I improves sleep both short term and long term, and does not appear to have side effects.

Your doctor may suggest medicines for your insomnia for short term (4 weeks to 3 months).

- There is not enough research to know if these medicines work or are safe for longer than 3 months.
- Medicines for insomnia have side effects that can be serious, including impaired alertness, changes in behavior, sleepwalking, or worsened depression.

Healthcare Common Procedure Coding System (HCPCS) Update

GOOD NEWS: HCPCS Updated for 2018

As the Department strives to improve its processes in order to ease the administrative burden on Medicaid providers, we are pleased to announce that the 2018 Healthcare Common Procedure Coding System (HCPCS) codes have been updated. This year's updates were not delayed by external factors and were able to be processed much quicker than in previous years. Our hope is that providers were relieved of some of the issues encountered when the annual updates are slower to reflect in the FFS files.

The Louisiana Medicaid fee-for-service (FFS) files have been updated to reflect the new and deleted Healthcare Common Procedure Coding System (HCPCS) codes effective for dates of service on or after January 1, 2018. Providers saw these changes on the remittance advice of January 30, 2018 for the following programs where applicable:

- ❒ DMEPOS
- ❒ Immunization Fee Schedule – Young Adult/Adult
- ❒ Professional Services
- ❒ Laboratory and Radiology
- ❒ Portable Radiology
- ❒ Ambulatory Surgical Centers (Non-Hospital)
- ❒ Free-Standing Rehabilitation Centers
- ❒ Take Charge Plus

Claims that were previously denied because the new 2018 codes were not on file, were recycled on the remittance of February 27, 2018. No action was required by providers.
Managed Care Organizations should be contacted for any remaining questions concerning their 2018 HCPCS updates.

New Medicaid Eligibility System to Launch Later This Year: Louisiana Medicaid Eligibility Determination System, or LaMEDS

The Louisiana Department of Health (LDH) is implementing a new Medicaid eligibility and enrollment system known as Louisiana Medicaid Eligibility Determination System, or LaMEDS. This new automated system will replace inefficient manual processes with modern new tools, technologies and electronic data sources.

Scheduled to launch in July 2018, LaMEDS includes a new Self-Service portal containing services for the public, partners and providers. The Provider Portal replaces the current Facility Notification System (FNS) and allows provider representatives, hospital representatives, and Support Coordination Agency (SCA) representatives to submit forms for Medicaid to process. The submitted forms are a means of notifying LDH regarding changes to information for individuals that may be requesting or receiving Long Term Care, Waiver, and Newborn health assistance.

Due to updated security requirements, all current representatives authorized to submit forms in FNS will be required to re-register in the new system. Impacted groups will receive more information on the re-enrollment process through direct contact from LDH.

If you have any questions, please contact msmcomm@la.gov.

ATTENTION PROVIDERS: PAYMENT ERROR RATE MEASUREMENT (PERM) FFY17 Currently Underway

Louisiana Medicaid is mandated to participate in the Centers for Medicare and Medicaid (CMS) **Payment Error Rate Measurement (PERM)** program which will assess our payment accuracy rate for the Medicaid and CHIP programs. If chosen in a random sample, your organization will soon receive a *Medical Records Request* from the CMS review contractor, CNI Advantage.

Please be advised that sampled providers who fail to cooperate with the CMS contractor by established deadlines may be subject to sanctioning by Louisiana Medicaid Program Integrity through the imposition of a payment recovery by means of a withholding of payment until the overpayment is satisfied, and/or a fine.

Please be reminded that providers who are no longer doing business with Louisiana Medicaid are obligated to retain recipient records for 5 years, under the terms of the Provider Enrollment Agreement.

For more information about PERM and your role as a provider, please visit the Provider link on the CMS PERM website: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Providers.html

If you have any questions, please call Catherine Altazan at 225-342-2612.

Online Medicaid Provider Manual Chapter Revisions as of February 1, 2018

Manual Chapter	Section(s)	Date of Revision(s)
Adult Day Health Care Waiver	9.10 Support Coordination	02/05/18
Behavioral Health Services	2.4 Coordinated System of Care Appendix D Approved Curriculum/ Equivalency Standards Table of Contents Appendix G Standardized Assessments for Members Receiving CPST and PSR	02/23/18 03/01/18
Home Health	Appendix E UB-04 Forms and Instructions	02/14/18
Hospice	Appendix E UB-04 Form and Instructions	02/14/18

Online Medicaid Provider Manual Chapter Revisions as of February 1, 2018 (continued)

Manual Chapter	Section(s)	Date of Revision(s)
Intermediate Care Facilities for Individuals with Intellectual Disabilities	Title Page Table of Contents 26.0 Overview 26.1 Admission Process 26.2 Covered Services 26.3 Recipient Behavior 26.4 Recipient Rights 26.5 Transfers and Discharges 26.6 Complaints 26.7 Record Keeping 26.8 Income Consideration in Determining Payment 26.9 Emergency Awareness 26.10 Decertification 26.12 Cost Reports 26.13 Audits and Desk Reviews 26.14 Sanctions and Appeals Appendix A Glossary of Terms Appendix B Developmental Disability Law Appendix C Contact Information Appendix D Claims Filing	12/22/17

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Remittance Advice Corner

2018 HCPCS and Fee Schedule Updates

The Louisiana Medicaid fee-for-service files have been updated to reflect the new and deleted Healthcare Common Procedure Coding System (HCPCS) codes effective for dates of service on or after January 1, 2018. Providers will begin to see these changes on the remittance advice (RA) of January 30, 2018.

Claims that have been denied due to use of the new 2018 codes prior to their addition to the claimsprocessing system will be systematically recycled with no action required by providers.

The applicable fee schedule updates are available on the Louisiana Medicaid website, www.lamedicaid.com.

Please contact the appropriate Managed Care Organization with any questions concerning their 2018 HCPCS updates. For questions related to this information as it pertains to fee-for-service Medicaid claims processing, please contact Molina Medicaid Solutions Provider Services at (800) 473-2783 or (225) 924-5040.

ATTENTION: LTC and ICF-IID FACILITIES

Beginning April 2018, monthly Optional State Supplement (OSS) payments will be generated by State of Louisiana Division of Administration.

To receive OSS payments for eligible residents of Long Term Care and ICF-IID Facilities after March 2018, the Facility **must** complete one of the following registration processes:

1. Assisted Registration
    a. Complete the OSS Provider Registration Workbook posted on LaMedicaid.com on the Online Forms or Files section (OSS Provider Registration Workbook)
    b. Vendors **must** also submit the ISIS EFT FORM which may be downloaded here: http://www.doa.la.gov/osrap/ISIS%20EFT%20Form.pdf.
    c. Submit the completed workbook, EFT form, and associated IRS W-9 by email to OSS@la.gov no later than **February 16, 2018.**

2. Self-Registration
    a. Register the Facility with Louisiana Division of Administration @ http://www.doa.la.gov/pages/osp/vendorcenter/vendorregn.aspx
    b. Submit a completed IRS W-9 form for the Facility to DOA-OSRAP, via e-mail at DOA-OSRAP-LAGOV@LA.GOV or fax (225) 342-0960**.**
    c. Vendors **must** also submit the ISIS EFT FORM which may be downloaded here: http://www.doa.la.gov/osrap/ISIS%20EFT%20Form.pdf.

If you have questions or need assistance with workbook completion or LAGOV registration, you may contact us by email at OSS@la.gov or by phone: (225) 342 – 0456 (Lorie), (337) 447 – 4145 (Shauna), or (225) 342 – 0441 (Kate).

Providers must continue to review the OSS Payment Remittances through the OSS web application in order to verify and issue individual recipient payments.

Return Payments must be made through the OSS system. **Payments should not be returned to Louisiana Department of Health.**

Refer to the OSS Provider User Guide located on the "Forms/Files/Surveys/User Manuals" tab at LaMedicaid.com for additional information.

Notification of Update:
2018 Assistant Surgeon and Assistant at Surgery Covered Procedures

Louisiana Medicaid has published the 2018 fee for service list of allowed procedures for assistant surgeons and assistant at surgery providers. The list titled, "2018 Assistant Surgeon and Assistant at Surgery List of Covered Procedures" has been posted to the LA Medicaid website (www.lamedicaid.com) under the ClaimCheck icon.

The changes are based on updates made by Change Healthcare, formerly the McKesson Corporation, to their 'ClaimCheck' product. Change Healthcare uses the American College of Surgeons (ACS) as its primary source for determining assistant surgery designations.

This list does not ensure payment but provides a comprehensive list of codes that may be allowed when billed by an assistant surgeon or by an assistant at surgery.

Please contact the appropriate Managed Care Organization with any questions concerning their 2018 updates. For questions related to this information as it pertains to fee-for-service Medicaid claims processing, please contact Molina Medicaid Solutions Provider Services at (800) 473-2783 or (225) 924-5040.

2018 Update to 'ClaimCheck' Product Editing

Change Healthcare, formerly the McKesson Corporation, routinely updates their 'ClaimCheck' product based on changes made to the resources used, such as Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) coding guidelines, the Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule Database, CMS National Correct Coding Initiative (NCCI) and/or provider specialty society updates. The 'ClaimCheck' product's procedure code edits are guided by these widely accepted industry standards.

The edit changes related to the 2018 HCPCS update went into effect for claims processed beginning with the remittance advice of January 30, 2018. Providers can expect that most claims will continue to edit in the same manner, but based on these updates, some claims could pay or deny for a different reason.

Please contact the appropriate Managed Care Organization with any questions regarding their updates. For questions related to this information as it pertains to fee-for-service Medicaid claims processing, please contact Molina Medicaid Solutions Provider Services at (800) 473-2783 or (225) 924-5040.

For Information or Assistance, Call Us!

Provider Enrollment	(225)216-6370	General Medicaid Eligibility Hotline	1-888-342-6207
Prior Authorization:		MMIS Claims Processing Resolution Unit	(225) 342-3855
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	MMIS/Recipient Retroactive Reimbursement	(225) 342-1739 1-866-640-3905
Hospital Pre-Certification	1-800-877-0666		
Provider Relations	1-800-473-2783 (225) 924-5040	Medicare Savings Program and Medicaid Purchase Hotline	1-888-544-7996
REVS Line	1-800-776-6323 (225) 216-(REVS)7387		
Point of Sale Help Desk	1-800-648-0790 (225) 216-6381	For Hearing Impaired	1-877-544-9544
		Pharmacy Hotline	1-800-437-9101
		Medicaid Fraud Hotline	1-800-488-2917