Louisiana Medicaid | Provider UPDATE

Volume 33, Issue 14 | October 2017

Summary of Recommendations from the American College of Physicians (ACP) Clinical Practice Guideline for the Management of Acute and Recurrent Gout

Table of Contents

Recommendation 1: The American College of Physicians (ACP) recommends that clinicians choose corticosteroids, nonsteroidal anti-inflammatory drugs (NSAIDs), or colchicine to treat patients with acute gout.

High-quality evidence showed that corticosteroids, NSAIDs, and colchicine are effective treatments to reduce pain in patients with acute gout.

Corticosteroids should be considered as first-line therapy in patients without contraindications because they are generally safer. Steroids are among the most effective anti-inflammatory medications available and have been shown to be as effective as NSAIDs for managing gout, with fewer adverse effects. Prednisolone at a dose of 35 mg for 5 days has been successfully used to treat acute gout. Adverse effects associated with long-term use of corticosteroids include dysphoria, mood disorders, elevation of blood glucose levels, immune suppression, and fluid retention. Corticosteroids are contraindicated in patients with systemic fungal infections or known contraindications.

Moderate-quality evidence showed no difference between different types of NSAIDs, including indomethacin. Adverse effects associated with NSAIDs include dyspepsia and potential gastrointestinal perforations, ulcers, and bleeding. Patients in whom NSAIDs may be contraindicated include those with renal disease, heart failure, or cirrhosis. Although indomethacin is commonly considered as the first-line NSAID for treatment of acute gout, there is no evidence that it is more efficacious than other NSAIDs, such as naproxen and ibuprofen.

Adverse effects associated with colchicine include gastrointestinal issues (such as diarrhea, nausea, vomiting, cramps, and pain) and, infrequently, headache and fatigue. Colchicine is contraindicated in patients with renal or hepatic impairment who are using potent cytochrome P450 3A4 inhibitors or P-glycoprotein inhibitors.

Grade: strong recommendation, high-quality evidence

Recommendation 2: ACP recommends that clinicians use low-dose colchicine when using colchicine to treat acute gout.

Moderate-quality evidence suggests that lower doses of colchicine (1.2 mg followed by 0.6 mg 1 hour later) are as effective as higher doses (1.2 mg followed by 0.6 mg/h for 6 hours) at reducing pain and are associated with fewer gastrointestinal adverse effects

Grade: strong recommendation, moderate-quality evidence

Recommendation 3: ACP recommends against initiating long-term urate-lowering therapy in most patients after a first gout attack or in patients with infrequent attacks.

Although evidence supports the benefits of using urate-lowering therapy for shorter durations to reduce gout flares, the benefits of long-term use (≥12 months) in patients with a single or infrequent gout attacks (<2 per year) have not been studied. Urate-lowering therapy is not necessary in cases where the patient would have no or infrequent recurrences. In cases of recurrent gout (≥2 episodes per year) or problematic gout (for example, gout associated with tophi, chronic renal disease, or urolithiasis), shared decision making with the patient is warranted to review possible harms and benefits of urate-lowering therapy.

Grade: strong recommendation, moderate-quality evidence

Recommendation 4: ACP recommends that clinicians discuss benefits, harms, costs, and individual preferences with patients before initiating urate-lowering therapy, including concomitant prophylaxis, in patients with recurrent gout attacks.

After resolution of acute gout, some patients may have recurrent episodes. Some patients have no or few attacks over many years, whereas others have more frequent attacks. Although evidence is inadequate to predict which patients will have more problems, those with higher serum urate levels (especially >476 μmol/L [>8 mg/dL]) are at greater risk. Some may prefer to initiate long-term therapy to prevent future gout attacks, whereas others may prefer to treat flares if they occur. Patients who decide not to initiate urate-lowering therapy can revisit their decision if they have multiple recurrences of acute gout. Febuxostat (40 mg/d) and allopurinol (300 mg/d) are equally effective at decreasing serum urate levels. However, these drugs are associated with adverse effects, including rash with allopurinol and abdominal pain, diarrhea, and musculoskeletal pain with febuxostat.

Data on the most appropriate duration of urate-lowering therapy are insufficient. Moderate- to high-quality evidence suggests that urate-lowering therapy reduces the risk for acute gout attacks after 1 year, but not within the first 6 months of treatment. High-quality evidence showed that prophylactic therapy with low-dose colchicine or low-dose NSAIDs reduces the risk for acute gout attacks in patients initiating urate-lowering therapy. Moderate-quality evidence also showed that continuing prophylactic treatment for more than 8 weeks was more effective than shorter durations to help prevent gout flares in patients initiating urate-lowering therapy.

Grade: strong recommendation, moderate-quality evidence

Grading Strength of Evidence

High: The reviewers are very confident that the estimate of effect lies close to the true effect for this outcome.
Moderate: The reviewers are moderately confident that the estimate of effect lies close to the true effect for this outcome.
Low: The reviewers have limited confidence that the estimate of effect lies close to the true effect for this outcome.
Insufficient: The reviewers have no evidence, they are unable to estimate an effect, or they have no in the estimate of effect for this outcome.

Reference: National Guideline Clearinghouse (NGC). Guideline summary: Management of acute and recurrent gout: a clinical practice guideline from the American College of Physicians. In: National Guideline Clearinghouse (NGC) [Web site]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2017 Jan 03. [cited 2017 Sep 20]. Available: https://www.guideline.gov

Palivizumab Recommendations for the 2017-2018 Respiratory Syncytial Virus (RSV) Season

There have been no updates to the palivizumab recommendations for the 2017-2018 RSV season. The current American Academy of Pediatrics (AAP) recommendations for the use of palivizumab are published in the Red Book®: 2015 Report of the Committee on Infectious Diseases (30th Ed).

Preventive measures for all high-risk infants: Control exposure to tobacco smoke; encourage breastfeeding for all infants in accordance with recommendations of the American Academy of Pediatrics; keep high-risk infants away from crowds and from situations in which exposure to infected people cannot be controlled (including group child care if feasible); instruct parents on the importance of careful hand hygiene; and all infants (beginning at 6 months of age) and their contacts (beginning when the child is born) should receive influenza vaccine as well as other recommended age-appropriate immunizations.

Reference: American Academy of Pediatrics. [Respiratory Syncytial Virus.] In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. Red Book: 2015 Report of the Committee on Infectious Diseases. 30th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2015

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.

Remittance Advice Corner

Attention Fee for Service (FFS) Louisiana Medicaid Providers:

Effective September 12, 2017, Fee-for-Service (FFS) Medicaid Pharmacy Program will implement an updated 340B billing policy. Pharmacy claims submitted with a 340B indicator from a non-340B pharmacy provider will deny at Point of Sale (POS). The non-340B provider must bill regular pharmacy stock. For more information, please refer to www.lamedicaid.com.

Attention Portable Radiology Providers:

The claims processing system has been updated to reflect new codes reimbursable to portable radiology providers beginning with dates of service January 1, 2016 going forward. Previously denied claims will be reprocessed for payment where appropriate without any action required on behalf of the provider. Payments will be reflected on the RA of September 5th, 2017.

For questions regarding this message and/or fee for service claims, please contact Molina Provider Relations at (800) 473-2783 or (225) 924-5040.

Updates to Healthy Louisiana related systems and claims processing changes are plan specific and are the responsibility of each health plan. For questions regarding Healthy Louisiana updates, please contact the appropriate health plan.

Attention Fee for Service (FFS) Louisiana Medicaid Providers:

Effective September 1, 2017 Fee for Service pharmacy claims for glecaprevir/pibrentasvir (Mavyret®) will have edits at Point of Sale (POS) similar to the other Hepatitis C direct acting antiviral agents. Please refer to http://www.lamedicaid.com for specifics.

Attention Fee for Service (FFS) Louisiana Medicaid Providers:

Effective September 15, 2017, Fee-for-Service (FFS) Medicaid Pharmacy Program will reimburse enrolled pharmacies for influenza vaccines and the administration of the vaccines by a pharmacist per program policy. For more information, please refer to http://www.lamedicaid.com/provweb1/Pharmacy/Influenza.htm.

Online Medicaid Provider Manual Chapter Revisions as of September, 2017

Manual Chapter	Section(s)	Date of Revision(s)
Behavioral Health Services	Table of Contents 2.1 Provider Requirements 2.3 Addiction Services Appendix B Glossary and Acronyms	09/08/17 09/08/17 09/08/17 09/08/17

Archived Online Medicaid Provider Manual Chapter Revisions as of September, 2017

Manual Chapter	Section(s)	Date of Omission (s)
Behavioral Health Services	Table of Contents 2.1 Provider Requirements 2.3 Addiction Services Appendix B Glossary and Acronyms	09/08/17 09/08/17 09/08/17 09/08/17

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