Louisiana Medicaid | Provider UPDATE

Volume 30, Issue 9 | November / December 2013

National Correct Coding Initiative Update

Preventive Care Codes vs. Immunization Administration Codes

On January 1, 2013, new Procedure-to-Procedure (PTP) edits were implemented in the Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI) that paired immunization administration codes with preventive care codes. Billing these code combinations on the same date by the same provider could have resulted in the preventive medicine code being denied. CMS has subsequently decided to permit states to deactivate these edits through the end of 2013, if they choose to do so stating, "It is understood that immunizations are commonly administered in conjunction with a comprehensive preventive medicine evaluation and that, when this occurs, both services are payable."

CMS has released updated guidance related to these services that no longer includes the option of deactivation of the code pairs. Effective January 2014, claims processing for Louisiana Medicaid fee for service (legacy) and Bayou Health Shared Savings Plans must reactivate these edits. However, CMS does provide the following guidance that will allow both the immunization administration and the preventive medicine evaluation and management (E/M) service to be reimbursed.

"If a Medicaid beneficiary receives one or more immunizations and a "significant, separately identifiable" preventive-medicine evaluation and management (E/M) service from the same provider on the same date of service, the provider's Medicaid claim(s) should include both the immunization administration code . . . and the comprehensive preventive-medicine E/M code . . . with modifier 25 appended . . . .

If the provider . . . bills a comprehensive preventive-medicine E/M code for the same day and does not append modifier 25, the Medicaid PTP edits will deny payment of the preventive medicine E/M code."

Legacy Louisiana Medicaid and Bayou Health Shared Plans claim processing will reimburse both the immunization administration and the preventive medicine E/M services when modifier 25 is properly appended to the preventive medicine procedure code. Further details will be provided on www.lamedicaid.com and in remittance advice messages about this change.

All Bayou Health Prepaid Plans have implemented NCCI editing, but each may have a different billing policy related to the mandate. It is understood that the Prepaid Plans will allow appropriate use of modifier 25 if the code pairs in question are activated in their claim processing systems. Please contact the Prepaid Plans directly for information specific to their implementation policies and any billing instructions.

For questions related to this information as it pertains to legacy Medicaid or Bayou Health Shared Savings Plans, please contact Molina Medicaid Solutions Provider Services at (800) 473-2783 of (225) 924-5040.

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Affordable Care Act Mandated Changes

All Providers

The Affordable Care Act, Section 1104 on Administrative Simplification, requires that healthcare operation rules become part of the healthcare regulatory framework. These operational rules serve as guidelines for electronic exchange of information. Mandated electronic funds transfer and electronic remittance advice operational rules with a January 1, 2014 effective date include:

- EFT (Electronic Funds Transfer) Enrollment;
- ERA (Electronic Remittance Advice) Enrollment;
- Dual delivery of paper/electronic ERA (835);
- Uniform use of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) code combinations in the ERA; and
- Use of the National Automated Clearing House Association (NACHA) Corporate Credit or Debit Entry with Addenda Record (CCD+Addenda) to facilitate EFT/ERA reassociation.

Molina is on schedule in making the necessary system changes to accommodate the rule requirements by the targeted implementation date. Listed below is a brief high level description of each operating rule and its impact on the provider community.

- RULE 380 EFT ENROLLMENT – Requires health plans to offer electronic EFT enrollment. Molina has required Louisiana Medicaid providers to participate in electronic funds transfer for many years. The EFT enrollment forms will be updated to accommodate the new required data elements and a new web application will be available to request updates.
- RULE 382 ERA ENROLLMENT – Requires health plans to offer electronic ERA enrollment. Molina currently offers a choice of v5010 835 to electronic claim submitters. Forms will be updated to accommodate the new required data elements and a new web application will be available to request 835 enrollment.
- RULE 370 EFT & ERA Reassociation (CCD+835) – Addresses sending of the NACHA CCD+ data elements to help providers reassociate health care payments made via EFT with payment data received by their financial institution. This rule standardizes timeframes between sending the V5010 835 and the receipt of the funds deposit.
- RULE 350 HEALTH CARE CLAIM ADVICE INFRASTRUCTURE – Defines dual-delivery (paper/electronic) of remits. Molina currently offers electronic v5010 835 remittance transactions to enrolled submitters as well as proprietary remittance advice reports via web access. Both will continue to be offered. This rule specifies use of the Master Companion Guide template for the v5010 835 transaction.
- RULE 360 UNIFORM USE OF CARC/RARC CODES in 835 – Identifies a set of four Core-defined Business Scenarios with a maximum set of Core-required code combinations that can be used to provide details in the 835 about claims adjustments or denials to providers. Molina provides a crosswalk between its proprietary error codes and the HIPAA (Core defined) Claim Adjustment Reason Codes on the lamedicaid.com website. This crosswalk will be updated with the new defined code combinations. The complete list can be found at www.wpc-edi.com at CODE LISTS.

Providers are encouraged to routinely check www.lamedicaid.com for informational updates or www.caqh.org/CORE_phase3.php for additional information regarding these requirements.

Affordable Care Act Enhanced Reimbursement Updates

All Providers

Bayou Health Prepaid Plan contract revisions have been completed to allow the Prepaid Plans to make enhanced reimbursements to designated physicians, physician assistants, and advanced practice registered nurses who meet the Affordable Care Act (ACA) requirements. The Department of Health and Hospitals (DHH) began reimbursing the plans for the enhanced rates in October 2013. The plans had until mid-November to begin reimbursing newly processed claims and until late December to adjust previously paid claims at the enhanced rate.

Bayou Health Shared Savings Plans and Legacy Medicaid

DHH reduced rates on the Professional Services fee schedule by 3.4 percent effective July 1, 2012 and an additional 1 percent effective February 1, 2013. In anticipation of the implementation of the proposed rule published by the Centers for Medicare and Medicaid Services (CMS) that mandated the ACA enhanced reimbursement, services rendered by physicians who chose a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine in the Medicaid provider enrollment process were exempted from the July 2012 and February 2013 rate reductions. In accordance with the final rule published by CMS in November 2012, this exemption remained in place until DHH fully implemented the ACA enhanced reimbursement for claims paid by Molina. This exemption was only effective for dates of service July 1, 2012 through August 19, 2013.

While many providers met requirements for exemption from the state rate reductions, not all met federal requirements for the ACA enhanced reimbursement. Reimbursement decreased to these providers for dates of service after August 19, 2013 when the exemption to state rate reductions ended.

Guidelines Developed for Didactic Training and Establishment of Competency of Direct Service Workers in Medication Administration and Non-Complex Nursing Tasks

Home and Community-Based Service Providers

On December 20, 2012, the Department of Health and Hospitals in conjunction with the Louisiana State Board of Nursing published a final rule in the *Louisiana Register*, Vol. 38, No. 12, related to training of direct service workers in medication administration and non-complex tasks. The rule allowed providers twelve months from the date of publication to prepare for compliance with direct service worker (DSW) training requirements. After December 20, 2013, the practice of physician delegation is no longer available as a mechanism to authorize DSWs to administer medications or to perform other tasks that may be required by the clients' comprehensive plan of care (CPOC). Under the provisions of the rule, the State Board of Nursing is allowing the registered nurse to delegate medication administration and other non-complex tasks to DSWs once the worker has successfully completed training and been deemed competent by the registered nurse to perform the assigned task.

Over the past several months, staff from the Office of Aging and Adult Services (OAAS), Office for Citizens with Developmental Disabilities (OCDD), and Health Standards has been meeting with the State Board of Nursing to develop guidelines to supplement the December 20, 2012 rule. Section 9245, Part C of the rule states, "A direct service worker who has not completed didactic training and demonstrated competency in accordance with guidelines established and approved by the Department of Health and Hospitals and the Louisiana Board of Nursing shall not be allowed to perform medication administration or any noncomplex tasks covered by this Rule". The work on the development of the guidelines was discussed in provider meetings around the state over the past year. The intent of the guidelines is to establish training, competency and a process by which the registered nurse may delegate non-complex nursing tasks to DSWs. On October 9, 2013, the Board of Nursing approved the final draft of the

Guidelines Developed for Didactic Training and Establishment of Competency of Direct Service Workers in Medication Administration and Non-Complex Nursing Tasks - *Continued*

guidelines which includes the following components:

- Responsibilities of both the registered nurse and the DSW,
- A list of delegable non-complex tasks and non-delegable complex tasks, and
- A procedure for the registered nurse to use in the delegation process.

The list of delegable and non-delegable tasks addresses some of the common tasks being performed by the DSWs; however, **this is not an all-inclusive list**. Some procedures not listed may require the registered nurse to perform an assessment and follow the rules of delegation given by the Board of Nursing to determine whether or not the task in question can be delegated. Some clients whose medical conditions require that complex tasks be performed on a daily basis cannot be delegated by the registered nurse.

The guidelines also include the following optional documents that may prove helpful to providers and registered nurses in complying with the process requirements:

- A sample form for the registered nurse to document competency of the trained DSW,
- Sample forms that include examples of person specific instructional guidance to be left in the client's home as a reference for trained DSWs, and
- Sample training modules in the areas of documentation, vital signs and universal precautions.

Staff from OCDD, OAAS and Health Standards will continue to meet with the Board of Nursing on a regular basis to provide feedback and address other unresolved issues as they relate to clients' needs for services in the community. A link to the guidelines will be posted on the following sites:

Health Standards Direct Service Worker Registry web page:
http://new.dhh.louisiana.gov/index.cfm/directory/detail/713

Office of Aging and Adult Services web page:
http://www.dhh.louisiana.gov/index.cfm/subhome/12/n/327
Office for Citizens with Developmental Disabilities:
http://new.dhh.louisiana.gov/index.cfm/subhome/11/n/8

A provider's failure to have DSWs, who administer medications and/or perform other non-complex tasks to clients, trained by December 20, 2013 may result in one or more of the following actions:

- Inability of the DSW to administer medications or perform other non-complex tasks to the client,
- Citations,
- Sanctions, and
- Possible recoupment of Medicaid funds.

Providers should immediately notify support coordinators and regional program offices so the CPOC for these clients can be adjusted to ensure continuity of care. Questions related to this policy change should be directed to:

Terry Cooper, RN
Health Standards Section
225-342-5780
Terry.Cooper@la.gov

Jeanne LeVelle, RN
Office of Aging and Adult Services
225-219-0222
Jeanne.LeVelle@la.gov

Angela Shockley, RN
Office for Citizens with Development Disabilities
504-364-6647
Angela.Shockley@la.gov

Remittance Advice Corner

All Providers

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

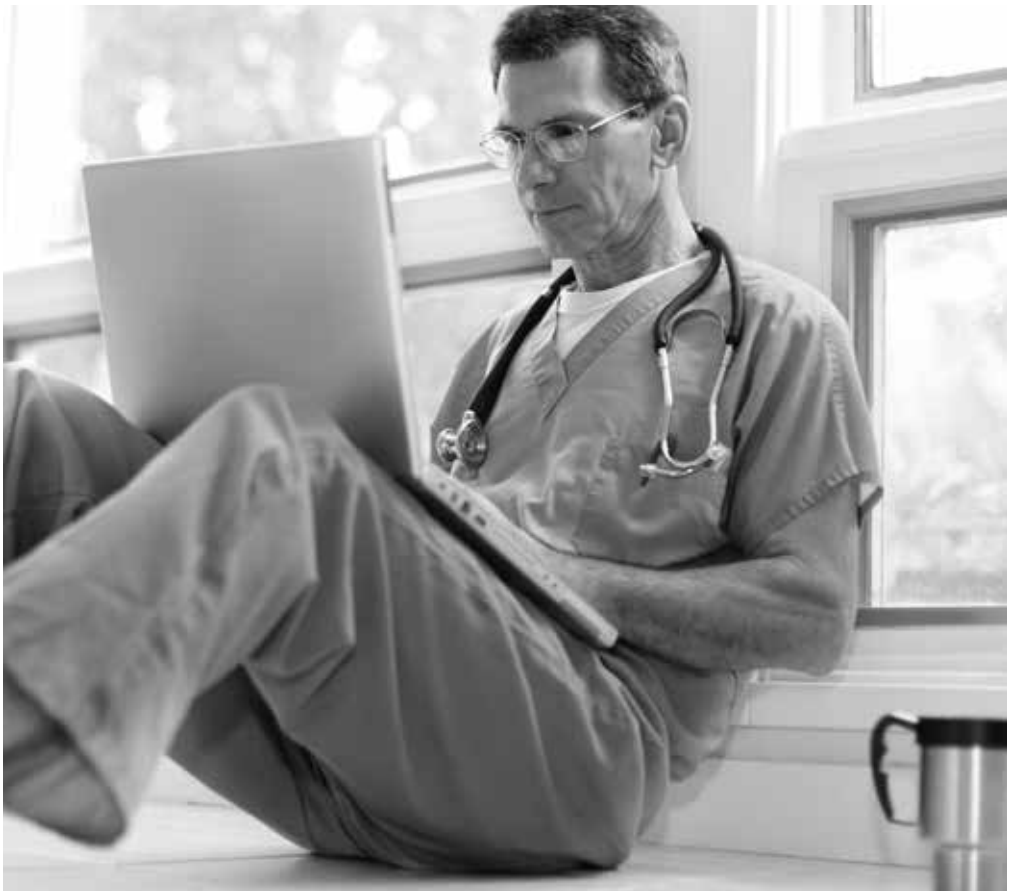
Attention Pharmacists and Prescribing Providers of Bayou Health Shared and Legacy Plans

Effective October 15, 2013 pharmacy claims billed for omalizumab (Xolair ®) for shared health plans or legacy recipients will require a prior authorization (PA). Claims billed without a PA will deny with EOB code 485 (PA required). See www.lamedicaid.com for more information.

Attention Providers that Submit Professional Crossover Claims Paper Crossover Claims Paid in Error

Claims for recipients who have Medicare and Medicaid coverage must be filed with the Medicare fiscal intermediary within 12 months of the date of service in order to meet Medicaid's timely filing regulations. Claims which fail to cross over electronically from Medicare must be submitted hard copy to Medicaid within six months from the date on the Medicare Explanation of Medicare Benefits (EOMB), provided that they were filed with Medicare within one year from the date of service. This policy is stated in the General Information and Administration Provider Manual – General Claims Filing Section, found at www.lamedicaid.com, directory link - Provider Manuals.

Due to a system calculation error, the dates for this timely filing edit (971 – Claim Exceeds Filing Limit Coins/Deduct) were not being correctly edited for Professional Crossover Claims that were submitted to Medicaid as paper claims. Claims that did not meet the filing requirement based on the Medicare EOB that was submitted with the claim that paid, but were paid due to this calculation error, have been identified and are being systematically voided on the 10/22/13 RA.



Providers should not resubmit any of these claims unless appropriate documentation supporting timely filing can be submitted with the claim. The documentation originally submitted with the claim DOES NOT support timely filing. If providers have claims for which they can produce documentation that supports timely filing, they should resubmit (1) the claim, (2) the Medicare EOB, (3) the Molina RA that supports the claim being filed timely (within 1 year from date of service and/or 6 months from the Medicare EOB payment date), (4) the Molina RA with the voided claim, and (5) a letter of explanation to: Molina Provider Relations. Attn: Correspondence Unit, P.O. Box 91024, Baton Rouge, LA 70821. If the dates of service are over two years old, any reconsideration of these claims will be sent from Molina to DHH for approval.

Attention Providers Regarding Edit 971

We are giving authorization for Molina to override the two (2) year timely filing edit on the related claims from this specific project. The provider will be responsible for documenting timely filing on those claims that are over two years old. If documentation of timely filing is not provided, the claims will deny with instructions not to resubmit.

Attention LTC, ICF-DD, ADHC and Hospice Room & Board Providers Information Related to Billing for September and October 2013

We have made revisions to the LTC regular and supplemental payment schedule for October 2013 to clarify when providers may receive payment in the month of October depending on the date of service on the claim(s).

Remittance Advice Corner - *Continued*

FOR ALL PROVIDER TYPES LISTED: Any claims billed and processed prior to the October 10th and October 17th cutoff with dates of service prior to September 2013 for private facilities will appear on the Remittance Advices/check writes of either 10/15/2013 and/or 10/22/2013. **FOR STATE OPERATED FACILITIES:** The check write dates of either 10/15/2013 and/or 10/22/2013 will include payments to State Operated Facilities.

FOR ADHC PROVIDERS: The system generated claims for September dates of service were paid at a reduced rate in error on the RA of 09/26/2013. These incorrectly paid claims will be voided on the 10/22/13 RA. Providers must get their 'regular' billing for September 2013 dates to Molina for processing no later than Noon on Thursday, October 17th, in order to have these claims processed for corrected payment on the RA of 10/22/2013. Providers that do not meet this deadline (the regular supplemental billing cutoff) will have the corrected claims processed in the regular LTC check write of 11/12/2013.

FOR PROVIDERS OTHER THAN ADHC PROVIDERS: The check write dated 10/29/2013 will include the processing of the **MOLINA system generated** Adjustments/ Voids to make needed adjustments to the provider submitted claims for payment of September 2013 claims which were made on the RA dated 09/26/2013. This check write will also include any other September claims submitted by providers for the regular supplemental billing cycle.
Please be sure that you submit bills for all of your September services prior to the October 17th cut-off date or your 09/26/13 payments will be voided. Providers should submit original claims for September services, not adjustments.

For questions related to this notification, please contact Molina Medicaid Solutions Provider Services at (800) 473-2783 or (225) 924-5040.

Attention All Providers

The diagnosis code 3051 (Tobacco Use Disorder) will be paid under Medicaid Managed Care (Bayou Health) for health plan recipients and by Molina for legacy Medicaid recipients. This diagnosis is not paid under LBHP through Magellan. Claims will be recycled on the 11/22/13 RA.

Please submit claims with a primary diagnosis of 3051 to the appropriate Bayou Health Plan or Molina for processing. Please refer to the Informational Bulletin 12-18 at www.makingmedicaidbetter.com for the complete list of behavioral health Diagnosis Codes that are excluded from payment by Magellan.

Attention Providers:
Termination of Provider Exemption of Professional Services Fee Schedule Cuts

On July 1, 2012, DHH reduced rates on the Professional Services fee schedule by 3.4 percent, and on February 1, 2013, it reduced them by an additional 1 percent. In anticipation of the implementation of the federally-mandated ACA enhanced reimbursement, DHH exempted from the July 2012 and February 2013 rate reductions those services identified in the proposed rule published by CMS in May 2012 when rendered by physicians who chose a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine in the Medicaid provider enrollment process administered by Molina.

This exemption remained in place until DHH fully implemented the ACA enhanced reimbursement for claims paid by Molina in accordance with the final rule published by CMS in November 2012. The exemption was effective for dates of service July 1, 2012 through August 19, 2013. For dates of service on or after August 20, 2013, the exemption no longer applies.

While many providers met requirements for exemption from the State rate reductions, not all meet federal requirements for the ACA enhanced reimbursement. Providers who met requirements for exemption from the State rate reductions but do not meet federal requirements for the ACA enhanced reimbursement will see their reimbursement decrease for dates of service after the exemption to State rate reductions ended on August 19, 2013.

Attention PCS Providers
Claims Denied in Error Due to Preparation for Changes in Service Limits

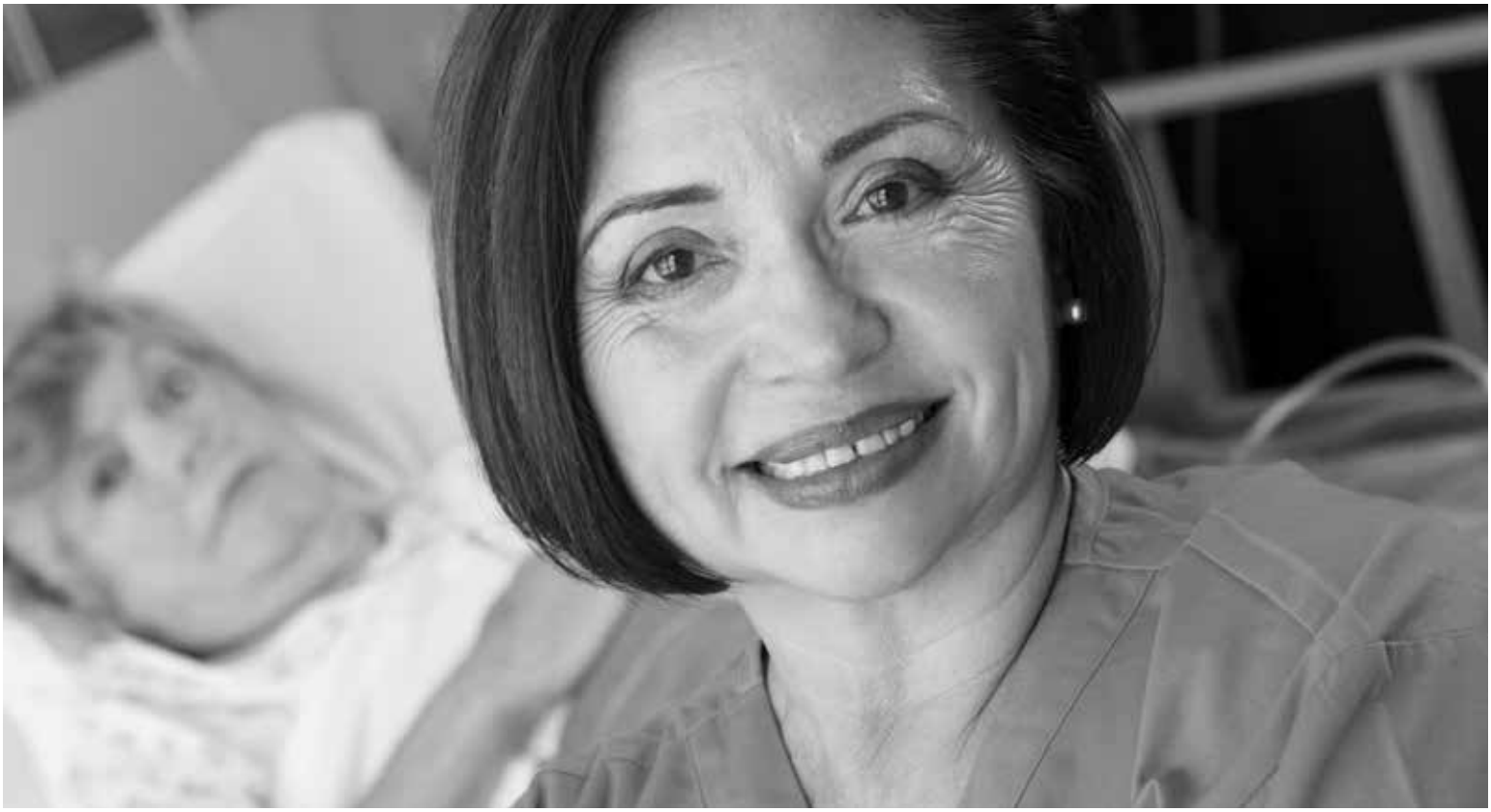
In preparation for service limit changes for LT-PCS, logic was altered prior to notifying providers of these changes. Starting with the RA of 10/8/13, claims processed for LT-PCS services for T1019 UB, T1019 UN, and T1019 UP with daily units greater than 32 and less than 47 denied with edit 542 (units exceed maximum daily allowed limit). This logic change is being reversed to put the educational edit 543 (units paid between 33 and 47) back in place temporarily and denied claims are being recycled. No action is required by providers. Please monitor RA messages and the web site for additional upcoming information concerning these service limit changes.

For questions related to this notification, please contact Molina Medicaid Solutions Provider Services at (800) 473-2783 or (225) 924-5040.

Attention Providers:
Deadline Extended for Affordable Care Act Enhanced Reimbursement

DHH has extended the deadline to submit a Medicaid Primary Care Services Designated Physician form and receive an effective date for enhanced reimbursement retrospective

Remittance Advice Corner - *Continued*



to January 1, 2013. In previous guidance, the deadline was June 28, 2013. The final deadline is now December 31, 2013. If your complete and correct form is received after December 31, 2013, you will receive enhanced reimbursement for eligible services rendered on or after the date the form is received.

For more information on the enhanced reimbursement, see the "ATTENTION PRIMARY CARE PROVIDERS: Affordable Care Act Enhanced Reimbursement of Primary Care Services Informational Bulletin" posted on www.lamedicaid.com.

Allergy Testing Update

The daily maximum units for billing allergy testing (CPT code 95017-'Allergy testing... with venoms…specify number of tests') has been updated to 30 in the legacy Medicaid claims processing system. This update is intended to accommodate variances in clinically appropriate and medically necessary testing. This change is effective for dates of service beginning January 1, 2013. Providers whose claims were processed by Molina and were denied due to the previous 15 unit daily limit may resubmit those claims.

For questions related to this update contact Molina Medicaid Solutions Provider Services at (800) 473-2783 or (225) 924-5040.

Home Health New Bill Type (BT)

ATTENTION HOME HEALTH PROVIDERS – NEW BILL TYPE ACCEPTED: Effective immediately, claims processing logic has been changed to accept the new NUBC UB Bill Type 32X for Home Health claims with dates of service October 1, 2013 forward. Claims previously submitted with this new Bill Type and denied with edit 042 (Invalid Bill Type) will be recycled on the 11/26/13 RA. Also, please remember that Home Health claims submitted electronically must be submitted with the file extension HOM. Claim files submitted without the HOM extension will be rejected for the Bill Type, because 32X is not an acceptable Bill Type for other institutional claims.

For questions related to this update contact Molina Medicaid Solutions Provider Services at (800) 473-2783 or (225) 924-5040.

Attention All Providers

Effective January 1, 2014, TPL Scope of Coverage Codes will be returned on all valid eligibility verification responses (271) from the MEVS, eMEVS, and batch MEVS for recipient that have private insurance on the service date requested.

This code information will appear in the response in the segment "Other or Additional Payor." This code information is available

Remittance Advice Corner - *Continued*

to all providers at the following link: http://www.lamedicaid.com/provweb1/TPL_Coverage/TPL_Coverage.htm.
If you have questions, please call Jackie Porta at 225-342-9463. Thank you for your cooperation in this matter.

Attention: MEVS Vendors

Effective January 1, 2014, TPL Scope of Coverage Codes will be returned on all valid eligibility verification responses (271) from the Louisiana MEVS. The verification response will return the CODE only. The Scope of Coverage code will be included in the EB05 field as a 2-digit code. This Scope of Coverage code may be followed by a single space and a second 2-digit Scope of Coverage code. These codes are intended to be presented without interpretation to the inquiring provider. A list of the Scope of Coverage codes and descriptions is available to all providers at the following link:

http://www.lamedicaid.com/provweb1/TPL_Coverage/TPL_Coverage.htm.

The TPL Scope of Coverage Codes descriptions are:

00 Not Available
01 Major Medical
02 Medicare Supplement
03 Hospital, Physician, Dental and Drugs
04 Hospital, Physician, Dental
05 Hospital, Physician, Drugs
06 Hospital, Physician
07 Hospital, Dental and Drugs
08 Hospital, Dental
09 Hospital, Drugs
10 Hospital Only
11 Inpatient Hospital Only
12 Outpatient Hospital Only
13 Physician, Dental and Drugs
14 Physician and Dental
15 Physician and Drugs
16 Physician Only
17 Dental and Drugs Only
18 Dental Only
19 Drugs Only
20 Nursing Home Only
21 Cancer Only
22 CHAMPUS/CHAMPVA
23 Veterans Administration
24 Transportation
25 HMO
26 Carrier declared Bankruptcy
27 Major Medical without maternity benefits
28 HMO/Ins Paid by Medicaid GHIPP program
29 Skilled Nursing Care
30 Medicare HMO (Part C)
31 Physician Only HMO
32 Pharmacy (PBM)
33 HMO No Maternity
If you have questions, please call Jackie Porta at 225-342-9463. Thank you for your cooperation in this matter.

Attention EPSDT Providers

Louisiana Medicaid has updated the EPSDT Periodicity Schedule to closely align with the current American Academy of Pediatrics (AAP) Bright Futures "Recommendations for Preventive Pediatric Health Care" schedule (copyright 2008). Providers may download a PDF version at www.lamedicaid.com under the link for Training/2013 Policy Updates/ Professional Services Program. The updated EPSDT Periodicity schedule is effective immediately.

Notable changes from the previous Louisiana Medicaid EPSDT periodicity schedule include:

- The objective vision screening, procedure code 99173-EP, now begins at age three.
- Preventive care services for adolescents are now expected to be performed annually. This change reflects the Department's goal to increase the number of annual preventive services in this age group and focus on adolescent health and improving health outcomes related to the adolescent population.
- Please note that Louisiana Medicaid does not require the "3-5 day" visit listed currently on the "AAP website schedule." Those services are typically performed while the infant is in the hospital and are not required to be duplicated.

If you have any questions please contact Molina Provider Relations (800) 473-2783 or (225) 924-5040.

Attention Providers of Influenza Vaccine

As part of the 2013 CPT update, a new influenza vaccine code, 90672 (Influenza virus vaccine....for intranasal use), was made available to providers on or after January 1, 2013. CPT code 90672 has been added to the Immunization fee schedule. Please note that procedure code 90672 can only be submitted with immunization administration codes 90473 or 90474. Medicaid will pay for the nasal administration of this vaccine. The vaccine code 90672 is to be submitted with a "zero" dollar amount as it is a part of the Vaccines for Children program provided at no cost to providers.

Molina has identified and recycled all claims for the new vaccine procedure code and the associated codes for the administration of the vaccine. These claims were recycled on the 11/05/13 RA and no action is needed by the providers.

If you have any questions please contact Molina Provider Relations (800) 473-2783 or (225) 924-5040.

New Payment Procedure for Providers Licensed by the Health Standards Section

All Providers

Effective January 6, 2014, **all licensing payments,** with the exception of sanction payments, must be mailed to a "lock box" that will be managed by J. P. Morgan Chase Bank instead of being mailed to the Department of Health and Hospital's Fiscal Management Office. The lock box is a secure post office box setup to receive payments and credit the specified account.

Each payment must be accompanied with a "Health Standards Section Payment Transmittal Form." J. P. Morgan Chase Bank will scan the payment (check or money order) and the transmittal form. Health Standards Section's staff will view the payment and transmittal form online and then enter the payment in their licensing system. The transmittal form is necessary to ensure the payment is credited to the correct facility and the appropriate licensing application. **A provider's failure to submit both the payment and the "Health Standards Section Payment Transmittal Form" will delay the approval process and may jeopardize the provider's licensure status.** The "Health Standards Section Payment Transmittal Form" is available at http://new.dhh.louisiana.gov/index.cfm/page/1737.

Providers must submit only **ONE CHECK OR PAYMENT PER STATE ID**. Payments **WILL NOT** be divided between multiple facilities, even for those facilities owned by the same entity. If one check is received for multiple ID numbers, payment will be applied to the first State ID number listed. Licensing payments must be sent to:

DHH Licensing Fee
P.O. Box 62949
New Orleans, LA 70162-2949

Documentation, such as the license application form, Disclosure of Ownership, SFM, Office of Public Health reports, etc., will continue to be mailed to:

Health Standards Section
P.O. Box 3767
Baton Rouge, LA 70821-3767

Providers SHOULD NOT send licensing payments to the Health Standards Section or the Office of Fiscal Management. Additional information about this new procedure can be found on the Health Standards Section's web site at http://new.dhh.louisiana.gov/index.cfm/page/1737 or by contacting one of the following staff:

All **Non**-Long Term Care Providers
Carla Lanoux (225) 342 6410

All Long Term Care Providers
Genella Carter (225) 342 1248

All HCBS and ICF/DD Providers
Deborah Hall (225) 342 5743

Options for the Treatment of Head Lice

Louisiana Drug Utilization Review (LADUR) Education

Jessica Helmer Brady, Pharm.D., BCPS

Clinical Assistant Professor

University of Louisiana at Monroe, College of Pharmacy

At the mere mention of head lice, most readers will have the urge to scratch their heads. *Pediculus humanus capitis*, the head louse, is a parasitic insect that may be found on the head, eyebrows, and eyelashes of humans. The louse is not able to hop or fly; it moves by crawling which allows for direct head-to-head transfer only. Children are most often infested, accounting for an estimated 6 million to 12 million infestations each year in the United States.[1]

Head lice are not an indicator of poor hygiene, nor do they transmit disease. Significant itching, skin inflammation, urticaria, and eczema can occur in large infestations, resulting in pain and restlessness. Secondary infection may also occur.[2]

Pediculus humanus capitis

The louse feeds by sucking tiny amounts of blood from the scalp. The louse's saliva has components with vasodilatory and anticoagulation properties that cause itching following sensitization to these components. With the first case of head lice, sensitization may take 4 to 6 weeks and itching may not develop until this time. At room temperature, head lice usually survive for less than 1 day away from the scalp, and their eggs cannot hatch at an ambient temperature lower than that near the scalp.[3]

In order for effective eradication, the head louse life cycle must be considered. It consists of three stages: nit, nymph, and adult louse. In the first stage of the life cycle, the nit, or egg, firmly attaches at the base of the hair shaft with a glue-like substance. Some sources may refer to the egg casing as the nit, rather than the egg itself. The nit does not develop a nervous system or become viable for several days. The second stage occurs when the nit hatches into the nymph after 7 to 12 days. The nymph continues to grow for 9 to 12 days, at which time the third stage (adult louse) is reached. The female adult louse starts to lay eggs in 1.5 days, can lay up to 10 eggs per day, and lives 3 to 4 weeks. The entire cycle from egg to louse could repeat every 3 weeks if left untreated.[3]

Diagnosis and Treatment

Considering the head louse life cycle, the ideal course of treatment of head lice is an agent with high pediculicidal (capable of killing lice) and ovicidal (capable of killing eggs) activity with minimal toxicity.[2] Complete eradication cannot be achieved if the entire louse life cycle is not interrupted. Household items such as hair brushes, stuffed animals, hats, etc. are not likely to be a source of transmission after one to two days without contact with the scalp. Thus, the major focus of control activities should be to reduce the number of lice on the head and to lessen the risks of head-to-head contact.[3]

Finding a live louse on the head is the standard for diagnosis of head lice infestation. Definitive diagnosis is often difficult because lice tend to avoid light and can crawl quickly. Use of a fine-toothed louse comb may aid in diagnosis if infestation is suspected. It has been suggested to use a lubricant (water, oil, or conditioner) to "slow down" the movement of lice and eliminate the possibility of static electricity when making the diagnosis.[4] If crawling lice are not seen, finding eggs or nit casings attached firmly within 1 cm (¼ inch) of the base of hair shafts suggests, but does not confirm, the person is infested. The nape of the neck and behind the ears are the most common sites to observe nits, although they may be easily confused with dandruff or other hair debris.[1, 3]

Treatment for head lice is recommended for persons diagnosed with an active infestation as evidenced by the presence of live lice. All household members and other close contacts should be checked; treatment is prudent for persons who share the same bed with actively-infested individuals. All infested persons (household members and close contacts) and their bedmates should be treated at the same time.[1]

Permethrin and pyrethrin can be used as initial treatment for head lice when local resistance is not suspected. The prevalence of resistance to specific products is unknown; however, in 2009, the American Academy of Pediatrics reported permethrin resistance close to 50% in the United States.[2,3] Patients who have failed these treatments may require prescription (Rx) only products. The use of shampoo/conditioner products or conditioners should be avoided prior to treatment as these products may impair the efficacy of the treatment. Patients should also avoid washing their hair for 1-2 days after the lice medication is removed.[1]

Options for the Treatment of Head Lice - *Continued*

Topical Treatment Options for Head Lice [3, 5-12]

Active Ingredient	Availability	Adverse Reactions / Contraindications / Warnings	Instructions for Use	Re-treatment
Permethrin 1%	Nix®, Permethrin Creme rinse and lotion formulation Approved in children ≥ 2 months	Pruritus, erythema, and edema	Apply to clean, damp hair Leave on for 10 minutes, then rinse off	Leaves a residue on the hair, designed to kill nymphs emerging from the 20% to 30% of eggs not killed with the first application Repeat treatment in 7 to 10 days if live lice are seen Re-treatment, preferably on day 9, is often suggested
Pyrethrins 0.33% plus Piperonyl Butoxide 4%	RID®, A–200®, Pronto®, Licide® Shampoo and oil formulations Approved in children ≥ 2 years	Possible allergic reaction in patients who are sensitive to ragweed Pruritus, local burning, stinging, irritation Contraindicated in patients hypersensitive to ragweed or chrysanthemums	Apply to dry hair Leave on for 10 minutes, use warm water to form a lather, shampoo, and rinse	No residual pediculicidal activity remains after rinsing 20% to 30% of the eggs remain viable after treatment Re-treatment at day 9 is optimal
Benzyl Alcohol 5%	Ulesfia® Lotion formulation Approved in children ≥ 6 months	Application site irritation, pruritus, erythema, application site anesthesia and hypoesthesia, ocular irritation	Apply to dry hair Leave on for 10 minutes, then rinse off	Treatment MUST be repeated in 7 days
Ivermectin 0.5%	Sklice® Lotion formulation Approved in children ≥ 6 months	Conjunctivitis, ocular hyperemia, eye irritation, dandruff, dry skin, and skin burning sensation (Incidence <1%)	Apply to dry hair Leave on for 10 minutes, then rinse off	Do not retreat

Options for the Treatment of Head Lice - *Continued*

Lindane 1%	Lindane Shampoo formulation Use with caution in infants	Has central nervous system toxicity in humans; several cases of severe seizures in children have been reported Contraindicated for use in patients with uncontrolled seizure disorders and in premature infants Use with extreme caution in children and in individuals who weigh less than 50 kg (110 lb) Second line therapy Use is not recommended by the American Academy of Pediatrics Resistance has been reported worldwide	Apply to dry hair Leave on for no more than 4 minutes Add water until lather forms, then rinse	Avoid retreatment
Malathion 0.5%	Ovide® Lotion formulation Approved in children ≥ 6 years	Skin/scalp irritation, chemical burn, stinging sensation, conjunctivitis if contact with eyes occurs High alcohol content (78% isopropyl alcohol); highly flammable	Apply to dry hair, allowing to air dry Wash off after 8 to 12 hours	Single application is adequate for most patients Reapply in 7 to 9 days if live lice are still seen
Spinosad 0.9%	Natroba™ Suspension formulation Approved in children ≥ 4 years	Application site erythema and irritation Ocular erythema	Apply to dry scalp first, then apply to and work through dry hair Leave on for 10 minutes, then rinse off	Reapply in 7 days if live lice are still seen

Options for the Treatment of Head Lice - *Continued*

Removal of nits immediately after treatment with a pediculicide is not necessary to prevent spread, because only live lice cause an infestation. However, individuals may want to remove nits for aesthetic reasons or to decrease diagnostic confusion.[3]

When treating head lice, supplemental measures can be combined with pharmacologic treatment; however, such non-pharmacologic measures generally are not required to eliminate a head lice infestation. For example, hats, scarves, pillow cases, bedding, clothing, and towels worn or used by the infested person in the 2-day period just before treatment is started can be machine washed and dried using the hot water and hot air cycles. Lice and eggs are killed by exposure for 5 minutes to temperatures greater than 53.5°C (128.3°F). Items that cannot be laundered may be dry-cleaned or sealed in a plastic bag for two weeks. Patients should avoid sharing any items that come in contact with the hair of an infested person. Vacuuming furniture and floors can remove an infested person's hairs that might have viable nits attached.[1] Products marketed for the removal of nits, including comb-out gel and combs, and household eradication are available, but not necessary.

Conclusion

Accurate diagnosis is the key to initiation of appropriate treatment of head lice. Close contacts should be treated only if evidence of infestation is also present, not prophylactically. Prescribers should consider safety, efficacy, local patterns of resistance, age of the patient, and ease of use when recommending treatment. Patients should be educated on the importance of following the product instructions closely, including retreatment if necessary, and of the supplemental measures recommended for treatment and prevention of future infestations.

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Online Medicaid Provider Manual Chapters

All Providers

The following Medicaid Provider Manual Chapters are available on the Louisiana Medicaid website at www.lamedicaid.com under the "Provider Manual" link. This list will be updated periodically as other Medicaid program chapters become available online.

Administrative Claiming
Adult Day Health Care Waiver
Ambulatory Surgical Centers
American Indian 638 Clinics
Case Management Services
Children's Choice Waiver
Community Choices Waiver
Dental Services
Durable Medical Equipment
EPSDT Health and IDEA-Related Services
End Stage Renal Disease
Family Planning Clinics
Family Planning Waiver (Take Charge)
Federally Qualified Health Centers
General Information and Administration
Greater New Orleans Community Health Connection
Home Health
Hospice
Hospital Services
Independent Laboratories
ICF/DD
Medical Transportation
New Opportunities Waiver (NOW)
PACE
Pediatric Day Health Care
Personal Care Services
Pharmacy
Portable X-ray
Professional Services
Residential Options Waiver
Rural Health Clinics
Supports Waiver
Vision (Eye Wear)

A recent revision has been made to the following Medicaid Provider Manual Chapters. Providers should review these revisions in their entirety at www.lamedicaid.com under the "Provider Manual" link:

Manual Chapter	Section(s)	Date of Revision
Adult Day Health Care Waiver	Entire manual	10/18/13
EPSDT Health and IDEA-Related Services	Section 20.4 – Program Requirements Appendix A – Procedure Codes Appendix C – Claims Filing	10/30/13
Pharmacy	Section 37.5 – Covered Services, Limitations, and Exclusions	10/30/13
Personal Care Services	Table of Contents Section 30.1 – LT-PCS Overview Section 30.2 – LT-PCS Covered Services Section 30.3 – LT-PCS Recipient Requirements Section 30.5 – LT-PCS Service Authorization Process Section 30.6 – LT-PCS Provider Requirements Section 30.7 – LT-PCS Service Delivery Section 30.8 – LT-PCS Record Keeping Section 30.9 – LT-PCS Incidents, Accidents and Complaints Section 30.10 – LT-PCS Reimbursement Section 30.11 – LT-PCS Fraud and Abuse Section 30.12 – Reserved Appendix A – LT-PCS Correspondence Appendix B – LT-PCS Agreement to Provide Services Appendix E – Billing Information Appendix F – LT-PCS Contact Information	11/05/13

Online Medicaid Provider Manual Chapters - *Continued*

Professional Services	Section 5.1 – Covered Services – Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	11/12/13
Medical Transportation	Table of Contents Section 10.3 – NEMT – Provider Requirements Section 10.6 – NEMT – Record Keeping Section 10.12 – Ambulance – Miscellaneous Policies Appendix H – Forms	11/13/13
General Information and Administration	Section 1.2 – Recipient Eligibility Appendix B – Contact/Referral Information	11/20/13
Personal Care Services	Table of Contents Section 30.8 – LT-PCS Record Keeping	11/21/13
Professional Services	Appendix A – Contact Information	12/4/13
Federally Qualified Health Centers	Table of Contents Section 22.1 – Covered Services Section 22.4 – Reimbursement	12/10/13

Manual chapters that have been reissued in their entirety or become obsolete remain available for reference under the "Archives" link. The following manual chapters have been moved to this link:

Archived Manual Chapters	
Adult Day Health Care Waiver	Entire manual reissued October 18, 2013
Dental Services	Entire manual reissued March 15, 2012
Elderly and Disabled Adult Waiver	Waiver program ended
EPSDT Health Services for Children with Disabilities	Entire manual reissued March 1, 2013 and renamed EPSDT Health and IDEA-Related Services
Mental Health Clinics	Services that were provided under these programs are now provided through the Louisiana Behavioral Health Partnership.
Mental Health Rehabilitation	
Multi-Systemic Therapy	
Psychological and Behavioral Health	

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