Louisiana Medicaid | Provider UPDATE

Volume 31, Issue 5 | December 2016

Nonopioid Treatment for Chronic Pain

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FDA Drug Safety Communication Regarding the Combined Use of Opioids & Benzodiazepines

According to the *CDC Guideline for Prescribing Opioids for Chronic Pain*, opioids are not first-line therapy for patients with chronic pain, except for those with cancer or receiving palliative or end-of-life care. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain and opioids should be considered only if the expected benefits for pain and function are expected to outweigh the risks for the patient. Studies have shown that several nonopioid treatments, both nonpharmacologic and pharmacologic, are effective in managing chronic pain.

Effective approaches to chronic pain should:

- Use nonopioid therapies to the extent possible
- Identify and address co-existing mental health conditions (e.g., depression, anxiety, PTSD)
- Focus on functional goals and improvement, engaging patients actively in their pain management
- Use disease-specific treatments when available (e.g., triptans for migraines, gabapentin/pregabalin/duloxetine for neuropathic pain) See http://www.cdc.gov/drugoverdose/pdf/alternative_treatments-a.pdf for more information regarding disease-specific treatments.
- Use first-line medication options preferentially
- Consider interventional therapies (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies
- Use multimodal approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors

Reference: Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. Available at: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

Examples of Nonopioid Medications for Chronic Pain			
Medication	**Magnitude of Benefits**	**Harms**	**Comments**
Acetaminophen	Small	Hepatotoxic, particularly at higher doses	First-line analgesic, probably less effective than NSAIDs
NSAIDs	Small to moderate	Cardia, GI, renal	First-line analgesic, COX-2 selective NSAIDs less GI toxicity
Gabapentin/pregabalin	Small to moderate	Sedation, dizziness, ataxia	First-line agent for neuropathic pain; pregabalin approved for fibromyalgia
Tricyclic antidepressants & serotonin /norepinephrine reuptake inhibitors	Small to moderate	TCAs have anticholinergic and cardiac toxicities; SNRIs safer and better tolerated	First-line for neuropathic pain; TCAs and SNRIs for fibromyalgia, TCAs for headaches
Topical agents (lidocaine, capsaicin, NSAIDs)	Small to moderate	Capsaicin initial flare/ burning, irritation of mucus membranes	Consider as alternative first-line, thought to be safer than systemic medications. Lidocaine for neuropathic pain, topical NSAIDs for localized osteoarthritis, topical capsaicin for musculoskeletal and neuropathic pain
Reference: http://www.cdc.gov/drugoverdose/pdf/alternative_treatments-a.pdf			

- On August 31, 2016, the U.S. Food and Drug Administration (FDA) published a safety announcement stating that an FDA review established that the growing combined use of opioid medicines with benzodiazepines has resulted in serious side effects, including slowed or difficult breathing and deaths.
- The FDA conducted and reviewed several studies indicating that serious risks are associated with the combined use of opioids and benzodiazepines. Based on these data, the FDA is requiring several changes to reflect these risks in the opioid and benzodiazepine labeling, including new *Boxed Warnings* and revisions to the *Warnings and Precautions*, *Drug Interactions*, and *Patient Counseling Information* sections of the labeling.
- Healthcare professionals should limit prescribing opioid pain medications with benzodiazepines only to patients for whom alternative treatment options are inadequate.
- If these medicines are prescribed together, dosages and duration of each drug should be limited to the minimum possible while achieving the desired clinical effect.
- Prescribers should also warn patients and caregivers about the risks of slowed or difficult breathing and/or sedation, and the associated signs and symptoms.
- Patients who take opioids with benzodiazepines should be instructed to seek medical attention immediately if they experience symptoms of unusual dizziness or lightheadedness, extreme sleepiness, slowed or difficult breathing, or unresponsiveness.

Reference: http://www.fda.gov/Drugs/DrugSafety/ucm518473.htm

Morphine Milligram Equivalents (MME)

HIGHER DOSAGE, HIGHER RISK. Higher dosages of opioids are associated with higher risk of overdose and death—even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk. Higher dosages haven't been shown to reduce pain over the long term. One randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy (with average final dosage 52 MME) and maintenance of current dosage (average final dosage 40 MME).

WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS? Patients prescribed higher opioid dosages are at higher risk of overdose death. In a national sample of Veterans Health Administration (VHA) patients with chronic pain receiving opioids from 2004–2009, patients who died of opioid overdose were prescribed an average of 98 MME/day, while other patients were prescribed an average of 48 MME/day.

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.

How much is 50 MME/day or 90 MME/day for Commonly Prescribed Opioids?	
50 MME/day	**90 MME/day**
50 mg of hydrocodone (10 tablets of hydrocodone/ acetaminophen 5/300)	90 mg of hydrocodone (9 tablets of hydrocodone/ acetaminophen 10/325)
33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)	60 mg of oxycodone (~2 tablets of oxycodone sustained-release 30 mg)
12 mg of methadone (<3 tablets of methadone 5mg)	~20 mg of methadone (4 tablets of methadone 5 mg)

CAUTION: Do not use the calculated dose in MMEs to determine dosage for converting one opioid to another—the new opioid should be lower to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics. Consult the medication label.

USE EXTRA CAUTION:

- Methadone: the conversion factor increases at higher doses
- Fentanyl: dosed in mcg/hr instead of mg/day, and absorption is affected by heat and other factors

HOW SHOULD PROVIDERS USE THE TOTAL DAILY OPIOID DOSE IN CLINICAL PRACTICE?

- Use caution when prescribing opioids at any dosage and prescribe the lowest effective dose.
- Use extra precautions when increasing to ≥50 MME per day* such as:
  - Monitor and assess pain and function more frequently.
  - Discuss reducing dose or tapering and discontinuing opioids if benefits do not outweigh harms.
  - Consider offering naloxone.
- Avoid or carefully justify increasing dosage to ≥90 MME/day.*

* These dosage thresholds are based on overdose risk when opioids are prescribed for pain and should not guide dosing of medication-assisted treatment for opioid use disorder.

For more information, refer to www.cdc.gov/drugoverdose/prescribing/guideline.html
Reference: https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

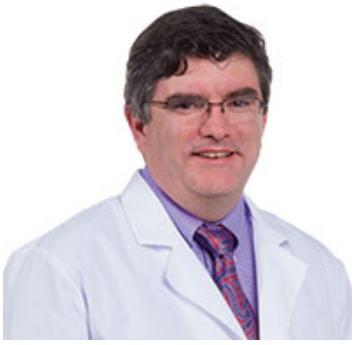
Palivizumab Recommendations for 2016 – 2017 RSV Season

There have been no updates to the palivizumab recommendations for the 2016-2017 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

Success: Electronic Health Records Adoption at Work



Ricky Bass, M.D., practices both internal medicine and pediatrics at LSU Health Science Center in Shreveport. He and his fellow providers at LSU-HSC have been using electronic health records (EHR) technology and participating in the Medicaid EHR Incentive Program since 2011.

Rosalyn Christopher, LDH's EHR Program Director, had the pleasure of speaking with Dr. Bass about his experiences transitioning to and practicing medicine with EHR technology. "The transition wasn't easy, but it was definitely worth it." He added, "When I get calls at night, I can access patient information through the EHR and make better decisions." Although not all physicians embrace the idea of EHRs, with proper training and support the transition is certainly doable.

When asked about the benefits of EHRs, Dr. Bass had quite a list. He likes that the EHR interfaces directly with Louisiana Immunization Network for Kids (LINKS), which allows him to see his patients' immunization records. With EHRs, providers can send messages to fellow providers and coordinate patient care with relative ease. Health activity reminders can be set to notify of important events – for instance, the need for a mammogram for a female patient over 40. Dr. Bass was especially pleased with how EHRs increase patient engagement through patient portals. Patients are able to send messages to their provider and see lab results – which allow for greater participation in their health.

Dr. Bass is one of more than 3,000 Medicaid providers who has adopted EHR technology and taken advantage of the EHR Incentive Program. Many of Louisiana's Medicaid providers have embraced EHR technology and are on their way to helping us achieve a Healthy Louisiana, we estimate there are approximately 5,000 Medicaid providers who have not adopted but who are eligible to participate in the EHR Incentive Program. Eligible providers can receive up to $63,750 over a six-year period. The quickly approaching deadline to adopt EHR technology for participation in the incentive program is December 31, 2016. If you're interested in participating, email us at ehrincentives@la.gov or call (225) 342-4810.

Payment Error Rate Measurement (PERM) Notice

The Payment Error Rate Measurement (PERM) 2017 Cycle has begun. This program involves the Centers for Medicare & Medicaid Services (CMS), in partnership with the States, measuring improper payments in the Medicaid/CHIP Programs. Therefore, if you, as a provider, are chosen in the random sample, for the FFY17 review period, full cooperation with the CMS Contractor is required. For more information about PERM and your Provider Responsibilities, please visit the website at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Providers.html

Should you have questions regarding PERM, you may contact Deanie Vincent at: 225-219-4279 or Deanie.vincent@la.gov .

Remittance Advice Corner

Alert
VFC Providers: Coverage of HPV Vaccine, CPT Code 90651

Louisiana Medicaid has become aware of an issue related to the Vaccines for Children (VFC) vaccine listing for CPT code 90651, (Human Papilloma Virus vaccine… (9vHPV)…), on the Immunization Fee Schedule for "Children/Adolescents".

In January of 2016, due to an inadvertent omission from the listing of VFC vaccines Medicaid received, CPT code 90651 was removed from the "Children/Adolescents" Immunization Fee Schedule. It has remained correctly listed on the "Young Adult" and "Adult" immunization fee schedules.

This vaccine should have remained on the "Children/Adolescents" listing as payable at $0.00 like other VFC provided vaccines. The effective date of service for inclusion on this fee schedule is on or after May 1, 2015 and the vaccine administration fee for this vaccine is therefore payable from that date forward. The "Children/Adolescents" fee schedules for 2016 are being updated on the Medicaid website, www.lamedicaid.com to correct the omission.

Healthy Louisiana managed care plans have been directed to identify claims that may have denied due to this situation and reprocess them for correct payment of the vaccine administration and inclusion of the vaccine in details needed for federal and other reporting of vaccine information. Fee for service Medicaid claims that denied inappropriately will be reprocessed with no action required by the provider.

Questions concerning Healthy Louisiana managed care organization (MCO) processes are to be directed to the appropriate MCO. Those questions related to Medicaid fee for service claims should be directed to Molina Provider Relations at (800) 473-2783 or (225) 924-5040.

Changes in Louisiana Medicaid Policy for 'Transplant-Related' Services

The Louisiana Department of Health (LDH) Medicaid policy concerning 'transplant related' services has changed. Effective with date of processing November 1, 2016, 'transplant related' services do not require an attached transplant prior authorization approval letter to be processed and paid. In the past, hospitals and physicians were required to attach the authorization letter to all transplant and transplant-related claims submitted to Molina for processing. This is no longer a requirement for 'transplant related' services.

This change does not impact claims for the actual organ transplant. All transplants must be authorized by the Prior Authorization Unit prior to the performance of the surgery. If the transplant is approved by the Prior Authorization Unit, the authorization letter is issued to the requesting hospital. When billing for the organ transplant, the hospital and all physicians involved must attach a copy of the approval letter and a dated operative report to the claims. As before, hospitals should share a copy of the transplant approval letter with all other providers involved in the patient's transplant.

Online Medicaid Provider Manual Chapter Revisions

Manual Chapter	Section(s)	Date of Revision(s)
Durable Medical Equipment	18.2 Specific Coverage Criteria	11/17/16
Pediatric Day Health Care	45.0 Overview 45.1 Covered Services 45.8 Quality Assurance	11/02/16

Archived Online Medicaid Provider Manual Chapter Revisions As of November 28, 2016

Manual Chapter	Section(s)	Date of Omission (s)
Durable Medical Equipment	18.2 Specific Coverage Criteria	11/17/16
Pediatric Day Health Care	45.0 Overview 45.1 Covered Services 45.8 Quality Assurance	11/02/16

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