Louisiana Medicaid | Provider UPDATE

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Newborn Screening Policy Update

All Providers

The KIDMED policy related to repeat newborn/neonatal heel stick screenings has been revised. Heel stick screening includes testing for 28 conditions such as phenylketonuria (PKU), congenital hypothyroidism, sickle cell disease, cystic fibrosis and many other heritable disorders or diseases. Hospitals with delivery units are required to screen all newborns via heel stick before discharge, regardless of the newborn's length of stay at the hospital. However, there is a greater risk of false negative results when screening is performed before 24 hours of age.

Providers are responsible for obtaining the neonatal screening results by contacting the hospital of birth, the health unit in the parish of the mother's residence or through the Office of Public Health's Genetics Diseases Program's web-based Secure Remote Viewer (SRV).

If a newborn was initially screened prior to 24 hours of age, or if the results of the initial screening are not available, the newborn must have another screening. The newborn should be rescreened at the first medical/KIDMED visit after birth, preferably between one and two weeks of age, but no later than the third week of life.

The initial or repeat neonatal screening results for the 28 health conditions must be documented in the medical record for all children less than six months of age. Children over six months of age do not need to be screened for these conditions unless it is medically indicated.

Information about this policy change can be viewed at www.lamedicaid.com under the "KIDMED Newborn Screening" link. Information about screening results can be obtained by contacting the Genetics Disease Program office at (504) 568-8254 or by visiting their website at www.genetics.dhh.louisiana.gov.

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Electronic Billing Changes Planned

All Providers

Effective January 1, 2012, all electronic billing must be conducted using the Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12, Version 5010, and the National Council for Prescription Drug Programs (NCPDP), Version D.0, transaction standards. Molina Medicaid Solutions is in the process of modifying its system to accept the 5010/NCPDP D.0 transactions and to establish testing procedures and processes for submitters, billers, and software vendors. Molina anticipates being ready for provider testing later this summer.

In preparation for 5010/NCPDP D.0 implementation, **providers should be working with their billing entities to ensure that they will be ready for testing**. Testing will be done with all 5010 transactions including the Errata Versions of ANSI 837-P (005010X222A1), 837-I (005010X223A2), and 999 Implementation Acknowledgment for Healthcare Insurance (005010X231A1).

The Electronic Data Interchange (EDI) Companion Guides, which will provide more detailed information, will be published on the Louisiana Medicaid Provider Support Center Web site at http://www.lamedicaid.com/provweb1/HIPAA/5010v_HIPAA_Index.htm in late June/early July 2011. Providers should access this web site on a regular basis for pre-implementation updates and reminders.

Direct Service Worker Emergency Rule Published

All Providers

The Direct Service Worker (DSW) Registry Rule which was published in the *Louisiana Register* on November 20, 2006 was suspended at the direction of House Concurrent Resolution (HCR) 94 of the 2010 Regular Session of the Louisiana Legislature. The Department of Health and Hospitals was directed to adopt new provisions governing the registry which would eliminate duplicative regulations and streamline the DSW process. In compliance with this directive, an emergency rule was published on April 20, 2011in the *Louisiana Register* in order to create a more manageable and efficient DSW process. The DSW registry will now maintain only the names of direct service workers who have had findings of abuse, neglect or misappropriation of an individual's property or funds placed against them.

The registry will no longer track employment, termination or training. Therefore, providers are no longer required to send forms DSW 7 or DSW 8 to the registry. All training requirements will now be governed by state licensing standards, Medicaid Standards of Participation and other program policy applicable to Medicaid enrollment. State surveyors will evaluate the provider's compliance with training requirements during on-site surveys, and all documentation relevant to employee training must be maintained and made available to surveyors.

Providers are required to access the registry prior to hiring an individual to assure there is no finding against the prospective employee. If there is such a finding, the individual shall not be hired. Providers are also required to check the registry every six months to assure the names of their current employees have not been placed on the registry. It is imperative that providers maintain printed confirmation from the registry web site to verify compliance with this requirement.

The emergency rule may be viewed on the Office of State Register web site at http://www.doa.louisiana.gov/osr/reg/1104/1104.pdf, and on the Health Standards web site at http://new.dhh.louisiana.gov/index.cfm/directory/detail/713 under Direct Service Worker Information. The Louisiana Direct Service Worker Registry may be accessed at www.labenfa.com. Questions regarding these changes should be directed to Health Standards at (225) 342-5794.

KIDMED Screening Periodicity Policy

All Providers

KIDMED providers are reminded to provide services according to the published KIDMED Screening Periodicity Policy. Periodic screenings performed on children less than two years of age must be at least 30 days apart, and periodic screenings performed on children/adolescents who are two years of age or older must be at least six months apart.

Whenever a medically necessary preventive/well-child screening is performed before the next scheduled screening, it should be billed as a KIDMED interperiodic screening. For example, if a seven day old infant has a KIDMED medical screening performed and three weeks later (21 calendar days) another screening is provided, the second screening should be billed as an interperiodic screening as it was performed less than 30 calendar days from the previous screening.

The complete published policy can be found on page 10 in the *2007 Louisiana Medicaid KIDMED Provider Training* online at www.lamedicaid.com under the "Training/Policy Updates," "Provider Training Packets/Policy Updates," "2007 Provider Training/Policy Updates" links.

Contact Molina Medicaid Solutions Provider Relations at (800) 473-2783 or (225) 924-5040 should you have any questions regarding this policy.

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.

- Administrative Claiming
- Adult Day Health Care Waiver
- Ambulatory Surgical Centers
- American Indian 638 Clinics
- Children's Choice Waiver
- Dental
- Durable Medical Equipment
- Elderly and Disabled Adult Waiver
- Family Planning Clinics
- Family Planning Waiver (Take Charge)
- Federally Qualified Health Centers
- General Information and Administration
- Home Health
- ICF/DD
- Medical Transportation
- Mental Health Clinics
- Mental Health Rehabilitation
- Multi-Systemic Therapy
- New Opportunities Waiver (NOW)
- Personal Care Services
- Pharmacy
- Psychological Behavioral Services
- Rural Health Clinics
- Vision (Eye Wear)

This list will be updated periodically as other Medicaid program chapters become available online.

Remittance Advice Corner

All Providers

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

Attention Professional Services Providers Procedure Codes Payable to Podiatrists

Effective January 1, 2011, procedure codes 97597 and 97598 (Debridement, open wound, including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface areas) are payable to podiatrists. The system has been updated to reflect this change. Claims for date of service January 1, 2011 – April 4, 2011 that were adjudicated prior to April 5, 2011, will be systematically adjusted on April 19, 2011. Continue to monitor future RAs for details regarding when the recycle of these claims will take place. Please contact the Provider Relations unit at (800) 473-2783 or (225) 924-5040 with questions concerning this issue.

Attention Professional Services Providers "Duplicate" Denials and Modifier Update

Revisions have been made to the complex duplicate logic in the claims processing system. This revision is intended to address the use of many anatomical "site-specific" and "repeat procedure" modifiers. Along with the "site-specific" modifiers, modifiers -76 (Repeat procedure or service by same physician or…) and -77 (Repeat procedure or service by another physician or…) will be recognized (see the ClaimCheck webinar presentation information under the ClaimCheck button on www.lamedicaid.com for a listing of the anatomic "site-specific" modifiers). When these modifiers are used appropriately, the "exact duplicate" denials related to error 813 should be reduced. Providers are reminded that improper use of modifiers to bypass claim editing solely to maximize reimbursement will be subject to review and administrative sanction by Louisiana Medicaid. Additionally, as indicated in provider agreement provisions, providers are to report and refund any and all overpayments.

To reduce the administrative burden for providers, claims with dates of service July 1, 2009, and forward that included these "site-specific" or the "repeat" modifiers and previously received a "duplicate" denial, have been recycled. This recycle appears on the RA of April 5, 2011. Providers should expect that some of the claims will continue to deny for the same error, especially when there have been multiple resubmissions. When applicable, some claims may deny for a different reason. For questions related to this update and recycle, please contact Molina Provider Services at (800) 473-2783 or (225) 924-5040.

Update to ClaimCheck Product Editing

Effective with the Remittance Advice of April 26, 2011:

McKesson's ClaimCheck product is routinely updated by McKesson Corporation 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 and Medicaid Services (CMS) Physician Fee Schedule database, and/or provider specialty society updates. The ClaimCheck product's procedure code edits are guided by these widely accepted industry standards. These edit changes will affect claims processed beginning with the remittance advice of April 26, 2011 forward. Providers may notice some differences in claims editing that includes Pre/Post-op Days, Incidental, Mutually Exclusive, Rebundling and Multiple Surgery Reductions. Providers should expect that some claims will continue to deny for the same error, but when applicable, claims may now pay or deny for a different reason. Providers will continue to be notified when these routine updates are made in the future. For questions related to this information, please contact Molina Provider Services at (800) 473-2783 or (225) 924-5040.

DHH to Transition to One Type of Eligibility Card

The Department of Health and Hospitals (DHH) currently issues two types of plastic swipe medical eligibility cards (MECs) for purposes of verifying Medicaid enrollment and service coverage or restrictions. A pink MEC is issued to women eligible for the TAKE CHARGE Family Planning Waiver which has a benefit package limited to only family planning services, and a white MEC is issued to individuals eligible for all other Medicaid eligibility programs.

Over the coming months, **DHH will transition to the issuance of a white MEC for all Medicaid eligibility programs** regardless of the scope of the benefit package. Therefore, it is important that providers verify eligibility and coverage limitations or restrictions on the date of service on all Medicaid enrollees by either logging in to the Louisiana Medicaid Provider Support Center on www.lamedicaid.com or calling the Recipient Eligibility Verification System (REVS) at 1-800-776-6323. Failure to do so may result in denied claims.

Carisoprodol and Its Associated Abuse

Louisiana Drug Utilization Review (LADUR) Education

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Carisoprodol is a prescription drug initially approved as a skeletal muscle relaxant in 1959; however, over the last decade, increased trends of abuse and diversion have been noted. According to data published by the Drug Enforcement Administration (DEA) on the trends in the diversion of controlled and noncontrolled pharmaceuticals, carisoprodol (Soma®) continues to be one of the most commonly diverted drugs throughout the country. Diversion methods include doctor shopping for the purpose of obtaining multiple prescriptions and forging prescriptions.[1]

Carisoprodol is a centrally acting skeletal muscle relaxant (SMR) indicated for the relief of discomfort associated with acute, painful musculoskeletal conditions in adults. It is approved only for short term use, up to a maximum of three weeks, because adequate evidence of effectiveness for prolonged use has not been established and because acute, painful musculoskeletal conditions are generally of short duration. The recommended dosage is 250-350 mg three times daily and at bedtime.[2] SMRs are commonly prescribed for musculoskeletal pain because it is perceived that they have a lower abuse potential than opioids and are often not classified as controlled substances.[3] While the mechanism of action of carisoprodol is not fully understood, it is thought to control pain by depressing the postsynaptic reflex and/or by causing sedation.[4] No evidence exists for a clinically significant effect other than sedation, with its sedative effects likely due to the metabolism of carisoprodol to meprobamate.[5, 6] As such, carisoprodol is a centrally acting SMR that does not directly relax skeletal muscles.[2]

It is believed that the high incidence of carisoprodol abuse most likely reflects dependence not on carisoprodol, but on the meprobamate metabolite.[5] Meprobamate, a Schedule IV controlled substance with a high abuse and addiction potential, is FDA-approved for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety.[7] Meprobamate produces sedation via GABA A receptors, further altering pain perception.[8] Meprobamate dependency, secondary to carisoprodol usage, has been reported with associated drug-seeking behavior and withdrawal symptoms.[4]

Carisoprodol is often prescribed as a short-term SMR as an adjunct to nonopioid analgesics for acute musculoskeletal pain, headaches and other painful conditions. However, case studies and reports suggest that the risk of dependence on carisoprodol may outweigh the benefit of skeletal muscle relaxation.[5] While carisoprodol is not a federally controlled substance, because of its associated abuse potential and reports of such, many states have also classified carisoprodol as a Schedule IV controlled substance, including Louisiana. As of 2010, 18 states have taken this measure (See table 1).[9]

Table 1[9]

Controlled Substance Status	State
Schedule IV	**AL, AZ, AR, FL, GA, HI, IN, KY, LA, MA, MN, NV, NM, OK, OR, TX, WA, WV**

Multiple case reports have demonstrated the potential abuse and dependence associated with the use of carisoprodol.[5, 10-14] It is presumably abused for its sedative or mood-altering effects.[5] Other CNS depressants, such as opioids or alcohol, are commonly abused with SMRs, particularly carisoprodol.[4] In a 1993 report by Rust and colleagues,[10] four patients in Atlanta, Georgia were reportedly receiving large quantities of carisoprodol and using it for a mind-altering effect. After chart review, three of these patients had received an average of 76.3 carisoprodol 350 mg tablets per patient per month over the course of one year. Musculoskeletal pain originating in the back or neck was the presenting complaint for which the prescriptions were provided. Chart notes also described drug-seeking behavior in these patients. Although the prescribing practitioners documented discussions with the patient about the addictive potential of narcotics and benzodiazepines, the practitioners seemed to prefer carisoprodol due to its non-controlled status.[10] Reeves and colleagues[11] have also written several articles examining carisoprodol abuse patterns among substance abusers. Of 20 patients surveyed, 65% admitted to abusing carisoprodol in a manner other than as prescribed. Fifteen percent admitted to using carisoprodol to modify the effect of another drug.[11, 12] These reports, along with others, demonstrate that carisoprodol is often abused with other drugs of abuse. In a review of Jefferson County, Alabama deaths from January 1, 1986 to October 31, 1997, in no case was carisoprodol the only drug detected by blood screening, or ever the only cause of death. Ethanol, diazepam, propoxyphene, hydrocodone, and alprazolam were frequent co-intoxicants.[13] Carisoprodol may also be illicitly used by patients to combat opioid withdrawal when narcotics are not available, to enhance the effect of a primary drug of abuse, or to blunt the unwanted effects of cocaine.[14, 15]

Warnings associated with carisoprodol[2]

- Since the sedative effects of carisoprodol and CNS depressants (including alcohol) or psychotropic drugs may be additive, appropriate caution should be exercised with patients who take more than one of these agents simultaneously.
- In postmarketing experience with carisoprodol, cases of dependence, withdrawal, and abuse have been reported with prolonged use. Carisoprodol should be used with caution in addiction-prone patients.
- There have been postmarketing reports of seizures in carisoprodol treated patients with most cases having occurred in the setting of multiple drug overdoses.

According to prescribing information, withdrawal symptoms have been reported following abrupt discontinuation of carisoprodol, especially after prolonged use.[2] Withdrawal symptoms are similar to those seen with barbiturates and meprobamate. They include restlessness, anxiety, insomnia, anorexia, and vomiting. Agitation, hallucinations, and seizures constitute severe withdrawal symptoms, with death being the most severe.[4] Other reported withdrawal symptoms include severe paravertebral spasms and pain, headaches, nausea, dysphoria, and back pain.[16] Since dependency is possible and withdrawal symptoms often include issues for which the drug was prescribed, such as back pain or related symptoms, carisoprodol should be tapered following long-term use.[4, 17] It has been reported that withdrawal symptoms may be seen during

the first 3 days after carisoprodol cessation.[17] It is suggested that chronic users be weaned from the drug over 3 to 5 days to avoid a withdrawal syndrome.[10] An alternative would be to reduce the daily dose by 25% of the previous day's dose until the patient has been tapered off of carisoprodol. The Department of Veterans Affairs Medical Center in Portland, Oregon developed a carisoprodol tapering schedule. This algorithm was published by the Oregon Drug Utilization Review Board and is available at: http://pharmacy.oregonstate.edu/drug_policy/pages/dur_board/newsletter/articles/volume4/4_8.pdf[18]

Louisiana Medicaid has imposed quantity limits on carisoprodol and certain other controlled substances. These limits became effective March 30, 2011. Patients are limited to 90 carisoprodol tablets every 90 days. This is a cumulative limit and applies to all strengths and combinations of carisoprodol.[19] More information is available at: http://www.lamedicaid.com/provweb1/Pharmacy/Phcy_Letter_Narc_Limit.pdf.

Carisoprodol-Containing Products[8]

- Carisoprodol 250 mg (Soma® 250)
  - Generic products available
- Carisoprodol 350 mg (Soma®)
  - Generic products available
- Carisoprodol/Aspirin/Codeine Phosphate 200 mg-325 mg- 16 mg (Soma® Compound with Codeine)
  - Generic products available
- Carisoprodol/Aspirin 200 mg-325 mg (Soma® Compound)
  - Generic products available

Important Points to Consider:

- While case reports have suggested a great potential for abuse and limited evidence of efficacy exists, carisoprodol continues to be frequently prescribed. It is only indicated for short-term use (up to 3 weeks), yet many patients receive large quantities and continue to receive new prescriptions each month.
- Healthcare practitioners should provide counseling to patients regarding the drug's abuse potential. Signs of abuse may include the use of multiple prescribers or pharmacies to obtain carisoprodol.[9]
- For patients currently taking carisoprodol, abrupt discontinuation should be avoided, utilizing a taper over several days to prevent withdrawal symptoms. Practitioners should consider alternative agents such as nonsteroidal anti-inflammatory drugs and nonpharmacologic interventions.[10] If a SMR is used, it should be prescribed at the lowest effective dose for a limited period of time.
- Healthcare providers should be vigilant regarding the abuse potential of carisoprodol and should play an active role in educating patients regarding the risk of dependence associated with long-term carisoprodol use.

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