Louisiana Medicaid | Provider UPDATE

Volume 30, Issue 3 | May/June 2012

Department of Health and Hospitals Responds to Providers' Concerns: Medicaid to Continue Paying Claims on 14-Day Processing Cycle

All Providers

The Louisiana Department of Health and Hospitals (DHH) is not moving forward with the final phase of a new Medicaid check write schedule which would have pushed Medicaid claims payments toward an approximate 21-day cycle. Medicaid claims will continue being paid on the current 14-day schedule.

Last summer the decision was made to move Medicaid claims processing from an approximate 7-day cycle to a 21-day cycle. Prior to this change, Louisiana was among the fastest-paying states in the country for Medicaid claims. The additional review time would have allowed DHH to use advanced analytics to pre-screen claims for fraud, waste and abuse.

Working with Molina, Medicaid's fiscal intermediary, DHH has determined that the additional seven days are not necessary to implement the pre-payment review process. An updated schedule of Medicaid check write dates is available on the Louisiana Medicaid website at http://www.lamedicaid.com/provweb1/recent_policy/2012_Medicaid_Checkwrite_Calendar.pdf.

Changes to the check write schedule are unrelated to implementation of BAYOU HEALTH. Three of the BAYOU HEALTH Plans – Amerigroup, LaCare and Louisiana Healthcare Connections – handle their own claims processing and payment, and providers who have contracted with these Plans should contact the Plan to receive their payment schedules. The other two BAYOU HEALTH Plans, Community Health Solutions and United Healthcare Community Plan, send their claims to Molina for payment, and these Plans follow the Medicaid program's check write schedule.

The changes also do not affect the payment schedule for Medicaid specialized behavioral health services through the Louisiana Behavioral Health Partnership, which are paid and processed through Magellan. Providers for services through the Partnership should check with Magellan to receive their payment schedule.

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Change in Hospice Prior Authorization Process Implemented

Hospice Providers

Effective May 1, 2012, prior authorization requests for hospice services must be requested through Molina Medicaid Solutions' electronic prior authorization (e-PA) process. The e-PA is a secure web application available to providers 24 hours a day, 7 days a week to request prior authorization and view the status of previously submitted requests.

All hospice requests, regardless of where the recipient resides or is being discharged from, must be submitted through e-PA with documentation that sufficiently supports the appropriateness of hospice services. Authorizations will be based on the recipient's terminal, not chronic, illness as defined in federal regulations in addition to objective clinical evidence.

Providers will receive a written notification of the decision after the request has been reviewed. Providers receiving a denial notice may submit a reconsideration request with new or additional information that supports medical necessity for the recipient's terminal stage of illness.

Hospice segments that are currently approved will remain in effect for the remainder of the current election period; however, requests for subsequent election periods must be submitted through the e-PA process.

Approval of prior authorization is not a guarantee for payment. Providers are responsible for verifying recipient eligibility on a monthly basis through the Recipient Eligibility Verification System (REVS)/ Medicaid Eligibility Verification System (MEVS).

Providers can obtain detailed information about the e-PA process from the *Electronic Prior Authorization (e-PA) Web Application User Manual* on the Louisiana Medicaid website at http://www.lamedicaid.com/ProvWeb1/Forms/UserGuides/ePAHelp.pdf or by calling 1-800-877-0666 and selecting option number two.

Remittance Advice Corner

All Providers

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

Attention All Providers: Policy clarification for Breast Reconstruction Surgery

Breast reconstruction surgery performed after a mastectomy is a covered service, but breast reconstruction to establish symmetry with contralateral breast is not covered. Tattooing the areola of the breast and reconstruction procedures to achieve symmetry of the breasts will not be covered by Louisiana Medicaid.

Billing for Recipients Enrolled in a BAYOU HEALTH Shared Plan

The following services are not provided by the Shared Plans and will continue to be prior authorized and/or paid through Molina:

Dental, Pharmacy, Waiver services, Durable Medical Equipment, Long-Term Personal Care Services, EPSDT Personal Care Services, Hospice, Emergency and Non-Emergency Transportation Services, Nursing Facility, Intermediate Care Facilities for the Developmentally Disabled, Specialized Behavioral or Mental Health professional services, Case Management, Adult Day Health Care, EPSDT Health Services and Early Steps case management and medical services.

All other services must be billed to the BAYOU HEALTH Shared Plan the recipient is enrolled with.

Billing for Recipients Enrolled in a BAYOU HEALTH Prepaid Plan

The following are services not provided by the Prepaid Plans and will continue to be prior authorized and/or paid through Molina:

Dental, Pharmacy, Waiver services, Long-Term Personal Care Services, EPSDT Personal Care Services, Hospice, Nursing Facility, Intermediate Care Facilities for the Developmentally Disabled, Specialized Behavioral or Mental Health professional services, Case Management, Adult Day Health Care, EPSDT Health Services and Early Steps case management and medical services.

All other services must be billed to the BAYOU HEALTH Prepaid Plan the recipient is enrolled with.

Reminder to BAYOU HEALTH Plan Providers

Claims for enrollees in the Prepaid Plans must be billed to and will be paid by the BAYOU HEALTH Plan. Claims for enrollees in the Shared Plans must be billed to Bayou Health Plan for pre-processing and then submitted by the Plan to Molina for adjudication and payment. Please refer to www.lamedicaid.com for the memo "Medicaid Billing Changes for Dates of Service Beginning February 1, 2012."

Attention Louisiana Medicaid Providers

The Louisiana Medicaid Nurse Helpline will be discontinued effective Monday, April 30, 2012, at 5:00pm. This service was provided through the contract for administration of the CommunityCARE and KIDMED programs. BAYOU HEALTH plans will assume responsibility for providing this service to their members as the program is implemented into each of the three Geographic Service Areas (GSA) of the state.

Members are to call:

Amerigroup –
1-800-600-4441

Community Health Solutions –
1-855-247-5248

LaCare –
1-888-756-0004

Louisiana Healthcare Connections –
1-866-595-8133

United Healthcare Community Plan –
1-866-675-1607

Providers in GSAs A and B should immediately remove all references to the Louisiana Medicaid Nurse Helpline from patient literature and office messaging. Providers in GSA C, the final area of the state scheduled for BAYOU HEALTH implementation, must have this process completed by April 30th.

Attention All Non-Emergency Transportation Providers

Claims for Non-Emergency claims and Prior Authorization for these services were being denied erroneously effective 2/1/12 as a result of implementation changes for the BAYOU HEALTH Plan. Corrections have since been made to correctly allow the claims to pay if an appropriate Prior Authorization is on file. Claims that were previously denied for February and March are being systematically recycled for potential payment and will show up on the 4/10/12 RA.

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

Providers can now reference obsolete manual chapters under the new "Archives" link. When a manual chapter is reissued in its entirety or when a manual chapter becomes obsolete, it will now be archived, but remain available for reference. The following manual chapters have been moved to this link:

Archived Manual Chapters	
Dental Services	Entire manual reissued March 15, 2012
Elderly and Disabled Adult Waiver	Waiver program ended
Mental Health Clinics	Services that were provided under these programs are now provided through the Behavioral Health Partnership program.
Mental Health Rehabilitation	
Multi-Systemic Therapy	
Psychological and Behavioral Health	

A recent revision has been made to the following Medicaid Provider Manual Chapter. Providers should review this revision in its entirety at www.lamedicaid.com under the "Provider Manual" link:

Manual Chapter	Section	Date of Revision
Hospital Services	Section 25.2 – Inpatient Services	04/30/12

Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

Louisiana Drug Utilization Review (LADUR) Education

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Attention-deficit/hyperactivity disorder (ADHD) is a commonly occurring neurobehavioral disorder in children and adolescents. According to the Diagnostic and Statistical Manual of Mental Disorders – 4th Edition (DSM-IV-TR), ADHD affects 3%–7% of school-age children in the United States.[1] These rates may vary depending on factors, such as the nature of the population sampled and the method of ascertainment. For example, recent surveys such as the 2007 National Survey of Children's Health (NSCH) report a higher prevalence of ADHD. The NSCH found that parents reported a 9.5% ADHD diagnosis in children ages 4–17 years, up from 7.8% in 2003, reflecting a 22% increase over four years. Furthermore, the NSCH reported that 66.3% of children with a current diagnosis of ADHD are receiving medication for the disorder.[2]

In November 2011, the American Academy of Pediatrics published updated clinical guidelines for the diagnosis, evaluation, and treatment of ADHD.[3] A summary of the key action statements contained in these guidelines include:

- All children ages 4–18 years who present with academic or behavioral problems, and symptoms of hyperactivity, impulsivity, or inattention, should be evaluated for ADHD by their primary care provider.
- The primary care provider should use the DSM-IV-TR criteria to diagnose ADHD (Table 1), and should rule out other potential causes. Information should be obtained from several sources involved in the child's care, such as parents, teachers, mental health clinicians, etc.
- An assessment for potential coexisting conditions should be conducted during the ADHD evaluation.
- Primary care providers should recognize ADHD as a chronic condition and, in turn, recognize this group as children and adolescents with special health care needs.
- Treatment of ADHD varies depending on the patient's age range, which has been expanded to include ages 4–5 years, as well as 13–18 years.
- Medication doses for ADHD should be titrated to reach maximum benefit with minimum side effects.

The most common treatment options for ADHD include pharmacotherapy, behavior therapy, or a combination of both. When choosing a medication for an individual patient careful consideration should be given to obtain the most favorable therapeutic outcome with the least adverse effects, as well as promote patient satisfaction and compliance.[4] Aspects to consider upon choosing a medication include cost, duration of action, ability to swallow capsules or tablets, time of day when most symptoms occur, time frame when homework is normally completed, effects of medication on sleep, and the patient's risk profile.[5]

Treatment of ADHD, according to the new guidelines, is divided into three categories, which include the following recommendations:

- **Preschool children ages 4–5 years**: Behavior therapy is recommended as first line. If an appropriate response is not seen with adequate behavior therapy, medication may be prescribed following a risk-benefit analysis.[3] Currently, dextroamphetamine and dextroamphetamine/amphetamine are the only medications FDA approved for this age range, but methylphenidate has been shown to be safe and effective.[5]
    - The Preschoolers with Attention Deficit/Hyperactivity Disorder Treatment Study (PATS) revealed that methylphenidate should probably be initiated at a lower dose in this age group and, although improvements were demonstrated in preschoolers' functioning, the degree of improvement was not as widespread as that observed in elementary school children.[6,7]
- **Elementary school children ages 6–11 years**: FDA-approved medications and/or behavior therapy should be used in this age group. A combination of the two is preferable.
- **Adolescents ages 12–18 years**: FDA-approved medications should be used to treat ADHD in this age range. Behavior therapy may also be used. Providers should evaluate patients in this group for signs of substance use or abuse before prescribing ADHD treatment. Another concern with this group is medication duration of action to cover symptoms while driving.[3,5]

Stimulant medications, mainly methylphenidate and amphetamines, are the most widely prescribed medications for ADHD and are available in many formulations. Stimulants have the most safety and efficacy data and are recommended as first-line treatment for ADHD. Agents within the stimulant class have similar efficacy and safety profiles; therefore, individual preferences must be considered upon initiating treatment. For example, if a patient experiences poor therapeutic outcomes or increased side effects while using a medication from the methylphenidate group, one of the amphetamines should then be considered.[5]

Stimulants should be started at a low dose and titrated on a 3-7 day schedule until the most effective dose is reached.[5] According to a recent study the most commonly reported

Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents - Continued

Louisiana Drug Utilization Review (LADUR) Education - Continued

side effects caused by stimulants were decreased appetite, gastrointestinal pain and headache.[8] Serious adverse effects related to stimulant use include hallucinations and other symptoms of psychosis. Much concern related to serious cardiovascular adverse events, such as sudden cardiac death, acute myocardial infarction and stroke, caused by stimulants has been voiced. However, a recent study including more than 1.2 million children and adolescents demonstrated no increased risk of serious cardiovascular events caused by ADHD medications;[9] these findings seem to be consistent with similar recent reports.[10,11] However, the prescribing information for these medications includes a black box warning regarding serious cardiovascular events, in addition to the black box warning about abuse potential.

Lisdexamfetamine is the newest addition to the stimulant class and is the only prodrug to date. It is therapeutically inactive but, upon ingestion, is converted to l-lysine and d-amphetamine. D-amphetamine is the therapeutically effective component. Safety and efficacy profiles of this medication are similar to other extended-release stimulants. The two main benefits of lisdexamfetamine are its long duration of action and decreased abuse potential.[4]

In cases where stimulant treatment fails or abuse and/or diversion may be a problem, there are three FDA-approved non-stimulant treatment options for ADHD: atomoxetine, extended-release guanfacine and extended-release clonidine. Atomoxetine is a selective norepinephrine reuptake inhibitor that has been extensively studied and proven to effectively treat ADHD. It is important to note that the full effects of atomoxetine may take several weeks up to a few months to be seen, unlike the stimulants whose efficacy is realized more quickly. Common adverse effects of atomoxetine include decreased appetite, somnolence, irritability, fatigue and abdominal pain. Dosing titration may help alleviate many of these. Serious adverse reactions associated with this medication include suicidality, aggression/psychosis, hepatic injury, and cardiovascular events. Atomoxetine prescribing information includes a boxed warning addressing suicidal ideation.[12]

Extended-release guanfacine and clonidine are alpha$_2$-adrenergic agonists that may be used to treat ADHD alone or in combination with stimulants. These medications are available in immediate-release formulations as well, but only the extended-release options are approved for use in children with ADHD. The most common adverse effects seen with these medications include somnolence, fatigue, and irritability. Minor decreases in heart rate and blood pressure may be seen as well.[13]

Goals of treatment of ADHD include improvement of symptoms, appropriate duration of action, coverage when most symptoms occur, and minimal side effect profile. Several FDA-approved medications are available to treat ADHD in children and adolescents (Table 2), with stimulants remaining the first-line treatment of choice. Providers should work closely with the patient and family to ensure medication adherence as well as optimal patient outcomes.

References

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DSM-IV-TR Diagnostic Criteria for ADHD1

A. Either (1) or (2)

(1). 6 or more of the following symptoms of **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

- often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
- often has difficulty sustaining attention in tasks or play activities
- often does not seem to listen when spoken to directly
- often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
- often has difficulty organizing tasks and activities
- often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
- is often easily distracted by extraneous stimuli
- is often forgetful in daily activities

(2). 6 or more of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity:

- often fidgets with hands or feet or squirms in seat
- often leaves seat in classroom or in other situations in which remaining seated is expected
- often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- often has difficulty playing or engaging in leisure activities quietly
- is often "on the go" or often acts as if "driven by a motor"
- often talks excessively

Impulsivity

- often blurts out answers before questions have been completed
- often has difficulty awaiting turn
- often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder.

Table 2: FDA-Approved Medications

Medication	Brand	Initial Titration Dose	Frequency	Time to Initial Effect	Duration, h	Maximum Dose	Available Doses
Mixed amphetamine salts	Adderall*	2.5 – 5.0 mg	QD – BID	20 – 60 min	6	40 mg	5, 7.5, 10, 12.5, 15, 20, & 30 mg tablets
	Adderall XR*	5 mg	QD	20 – 60 min	10	40 mg	5, 10, 15, 20, 25, & 30 mg capsules
Dextroamphetamine	Dexedrine*/ Dextrostat	2.5 mg	BID – TID	20 – 60 min	4 – 6	40 mg	5 mg tablets (both), 10 mg tablets (Dextrostat only)
	Dexedrine Spansule*	5 mg	QD – BID	≥60 min	≥6	40 mg	5, 10, & 15 mg capsules
Lisdexamfetamine	Vyvanse	20 mg	QD	60 min	10 – 12	70 mg	20, 30, 40, 50, 60, & 70 mg capsules
Methylphenidate	Concerta	18 mg	QD	20 – 60 min	12	54 mg (<13 y); 72 mg (≥13 y)	18, 27, 36, & 54 mg capsules
	Methyl ER	10 mg	QD	20 – 60 min	8	60 mg	10 & 20 mg tablets
	Methylin	5 mg	BID – TID	20 – 60 min	3 – 5	60 mg	5, 10, & 20 mg tablets and liquid and chewable forms
	Daytrana	10 mg	Apply for 9 h	60 min	11 – 12	30 mg	10, 15, 20, & 30 mg patches
	Ritalin*	5 mg	BID – TID	20 – 60 min	3 – 5	60 mg	5, 10, & 20 mg tablets
	Ritalin LA	20 mg	QD	20 – 60 min	6 – 8	60 mg	20, 30, & 40 mg capsules
	Ritalin SR*	20 mg	QD – BID	1 – 3 h	2 – 6	60 mg	20 mg capsules
	Metadate CD	20 mg	QD	20 – 60 min	6 – 8	60 mg	10, 20, 30, 40, 50, & 60 mg capsules
Dexmethylphenidate	Focalin*	2.5 mg	BID	20 – 60 min	3 – 5	20 mg	2.5, 5, & 10 mg tablets
	Focalin XR	5 mg	QD	20 – 60 min	8 – 12	30 mg	5, 10, 15 &20 mg capsules
Atomoxetine	Strattera	0.5 mg/kg per d, then increase to 1.2 mg/kg per d; 40 mg/d for adults and children at >154 lb up to 100 mg/d	QD – BID	1 – 2 wk	At least 10 – 12 h	1.4 mg/kg	10, 18, 25, 40, 60, 80, & 100 mg capsules
Extended-release guanfacine	Intuniv	1 mg/d	QD	1 – 2 wk	At least 10 – 12 h	4 mg/d	1, 2, 3, & 4 mg tablets
Extended-release clonidine	Kapvay	0.1 mg/d	QD – BID	1 – 2 wk	At least 10 – 12 h	0.4 mg/d	0.1 & 0.2 mg tablets

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Hospital Pre-Certification	1-800-877-0666
Provider Relations	1-800-473-2783 (225) 924-5040
REVS Line	1-800-776-6323 (225) 216-REVS (7387)
Point of Sale Help Desk	1-800-648-0790 (225) 216-6381

General Medicaid Eligibility Hotline	1-888-342-6207
LaCHIP Enrollee/Applicant Hotline	1-877-252-2447
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MMIS/Recipient Retroactive Reimbursement	(225) 342-1739 1-866-640-3905
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