Louisiana Medicaid | Provider UPDATE

Volume 29, Issue 5 | September/October 2011

Louisiana Medicaid to Eliminate Standard Paper Remittance Advices

All Providers

Effective November 1, 2011, Louisiana Medicaid will no longer print and mail standard paper remittance advices (RAs) to providers, billing agents, or other entities representing providers. This change will affect all providers who receive standard paper RAs except Friends and Family Transportation providers.

RAs will be posted weekly in a downloadable and printable PDF format on the secure side of the Louisiana Medicaid web site under the "Weekly Remittance Advices" link. Providers will have immediate access to RAs each Monday morning eliminating mail wait time and can download and save RAs electronically reducing the cost of filing and storing paper documents. In addition, use of the "search" function will allow providers to locate recipient specific claims information. These documents will only remain available online for five weeks.

Providers who are not registered on the Louisiana Medicaid web site, www.lamedicaid.com, must register in order to access the website's secure portal. Once registered, providers may grant logon access to appropriate staff and/or representative business partner entities needing access to their RAs. Individuals who are allowed to access RAs will have the ability to download, save or print the documents for reconciling accounts.

RAs will be both mailed and posted on the web site during a one month 'grace' period from October 1, 2011 to November 1, 2011. Providers should use this time to implement procedures for appropriate individuals to access this information online.

If assistance is needed with web registration or web technical issues, providers may contact the Molina Technical Support Help Desk at (877) 598-8753. Questions concerning this transition may be directed to Molina Provider Relations at (800) 473-2783 or (225) 924-5040.

This change does NOT affect 835 electronic remittance advices. Procedures and policies currently in place for HIPAA 835 electronic RAs remain the same.

Table of Contents

Remittance Advice Corner

All Providers

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

Attention Professional Service Providers: Billing Diagnostic Heart Catheterizations

It has been brought to the Department's attention that clarification is needed regarding the billing of a therapeutic cardiovascular intervention on the same date of service as a coronary angiography. This message is intended to provide clarification for providers who perform and bill for these services.

Coronary angiography without concomitant left heart catheterization should not be billed to report catheter introduction and position within the vessel when performing a therapeutic cardiovascular intervention (such as balloon angioplasty and intracoronary stent placement). This is considered an integral part to the primary procedure; therefore, it should not be reported separately.

The only instance when it would be appropriate to report coronary angiography without concomitant left heart catheterization on the same date of service as a therapeutic cardiovascular would be if a true diagnostic angiography was performed, and documentation supports the performance and necessity for the procedure. Instances which would be appropriate for separate reimbursement include occasions in which no previous angiographic study is available, insufficient previous angiography, or a change in the patient's condition. In order to appropriately bill for both of these services on the same date of service, providers should append the coronary angiography with the appropriate modifier to identify it as a distinct procedural service.

Providers are reminded that the medical record acts as the only means to support services billed. If the medical record does not support the necessity and performance of a true diagnostic angiography, the claim for the angiography will be determined as an overpayment and is subject to recoupment.

Please contact the Molina Provider Relations unit at (800) 473-2783 or (225) 924-5040 with questions concerning this issue.

ClaimCheck Processing Update for Add-On Procedure Codes

Effective with the Remittance Advice of August 18, 2011, claims processing will now also "look" for a paid primary procedure code in claims history before the final adjudication of the add-on code. Prior to this update, both the primary and the add-on codes had to be submitted on the same claim and process through ClaimCheck at the same time. Add-on procedure codes will continue to deny if they go through ClaimCheck while the primary code is in Medical Review. In this circumstance, providers must re-submit the add-on code after the primary code has been paid.

Claims that have received denial code 945 (Add-on procedure is invalid without primary) will be systematically recycled. No action is required by the provider. Those add-on codes that have the appropriate primary code paid in history should now be reimbursed. Some claims may continue to deny with the 945 denial code or for a different reason. The recycle is anticipated to occur on the remittance of August 25, 2011. Please contact Molina Provider Relations at (800) 473-2783 or (225) 924-5040 if there are any questions.

Attention Professional Service Providers: Pathology Consultations Performed during Surgery

A system issue has been identified which was causing claims billed for the professional component of procedure codes 88333 (pathology consultation during surgery; cytologic examination, initial site) and 88334 (pathology consultation during surgery; cytologic examination, each additional site) to deny with error code 182 (procedure claim type conflict) when performed in the hospital setting. This system issue has been corrected and claims billed on or after August 12, 2011 should process appropriately. Claims that previously denied for this issue for dates of service October 1, 2009 through August 11, 2011 that were adjudicated prior to August 12, 2011 will be recycled on September 6, 2011 and no action is required from providers. Please contact the Molina Provider Relations unit at (800) 473-2783 or (225) 924-5040 with questions concerning this issue.

Attention Professional Service Providers: Providing Services to Phase IV LaCHIP (SCHIP) Eligibles

It has been brought to the Department's attention that clarification is needed regarding the eligibility period of Phase IV LaCHIP recipients. This program provides prenatal care services, from conception to birth, for low income uninsured mothers who are not otherwise eligible for other Medicaid programs. This certification period begins with the first month of eligibility and continues without interruption until the pregnancy ends. There is no post partum eligibility period in this program.

Medicaid payments received by providers for inappropriate services are subject to review, recoupment and sanction.

Attention Durable Medical Equipment Providers of Cochlear Implant and Supplies

Please note the following DME HCPCS code which is being discontinued (10/31/2011) and the appropriate replacement codes which are to be submitted for prior authorization (PA) request dated 11/01/2011 forward. The PA requirements and medical necessity criteria that were applicable for the discontinued code apply for the replacement codes.

Discontinued code	Replacement codes
L8620	L8623
	L8624

The payment amounts for the replacement codes are noted on the updated fee schedule which can be found on www.lamedicaid.com.

Attention Hospital Providers

Effective with dates of service on or after November 1, 2011, the UB-04 claim processing has been changed to reflect the new guidelines according to the National Uniform Billing Committee (NUBC). The claims processing system has been changed to reflect the new "Point of Origin" (form locator 15) formally called "Source of Admission."

Any questions should be directed to Provider Relations.

Timely Submission of Precertification Requests

All Providers

The Molina Medicaid Solutions Pre-Certification Unit has noticed an increase in denials for inpatient hospital precertification requests that were not submitted timely. In an effort to educate providers on this issue, a web notice, "The Facts for Submitting Timely Precertification Requests," has been prepared that includes information about the submission process and a list of frequently asked provider questions and answers.

In this notice providers will find information about submitting a request when a patient's status is being changed from observation to inpatient. In addition, providers will find answers to questions such as, "What should a provider do when a denial is received because the request wasn't submitted timely?" and, "What are providers' options when a denial is upheld and the patient is still in the hospital?"

The entire web notice can be viewed at www.lamedicaid.com under the Acute Precert link. All questions regarding the precertification process should be directed to the Pre-Certification Unit at 1-800-877-0666.

Training Videos Released

All Providers

Nine new training videos are now available to assist nursing facility providers with completing the form "Notification of Admission, Status Change, or Discharge for Facility Care" (BHSF Form 148). These videos were developed by Louisiana Medicaid to give nursing facility providers specific instructions on how to complete the electronic BHSF Form 148 when reporting admissions, transfers, status changes and deaths of nursing facility residents. The videos are available to providers on the Facility Notification System website at https://bhsfweb.dhh.louisiana.gov/dhh148.

Any question that providers may have about these videos should be e-mailed to dhhproviderrequests@la.gov.

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
- Greater New Orleans Community Health Connection (GNOCHC)
- Home Health
- Hospitals
- 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
- Supports Waiver
- Vision (Eye Wear)

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

Combination Therapy with ACE inhibitors and ARBs in Heart Failure

Louisiana Drug Utilization Review (LADUR) Education

Adam Pate, Pharm.D.
Clinical Assistant Professor
University of Louisiana at Monroe
College of Pharmacy

Introduction

Angiotensin converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARBs) have garnered considerable attention regarding their place in the management of heart failure (HF). The benefits of ACE inhibitor therapy in heart failure are widely accepted, and national guidelines recommend they be used as primary therapy in these patients.1, 2 In fact, the American College of Cardiology Foundation/ American Heart Association 2009 focused update to the guidelines for the diagnosis and management of Heart Failure in adults cite ACE inhibitors as the best-studied medication class for use in HF, exhibiting multiple areas of benefit.2 ARBs are considered an acceptable alternative for patients who are intolerant to ACE inhibitors due to a cough or angioedema, but they are not first-line agents for general use in HF.1, 2 Dual blockade with ACE inhibitors and ARBs can be considered in HF patients with a reduced ejection fraction who have persistent symptoms or worsening HF, in spite of being on maximal doses of beta-blockers and ACE inhibitors.1 A large number of clinical trials have been conducted to evaluate dual blockade of the renin-angiotensin-aldosterone system (RAAS), and to determine the potential benefits of ACE inhibitors and ARBs when used in conjunction. Unfortunately, the results of these trials do not provide a clear-cut answer to the question of whether ACE inhibitors and ARBs should be utilized together. Rather, they demonstrate both potential benefits and harms associated with this strategy, leaving the ultimate decision of the risks versus benefits of dual therapy solely to the practitioner and the patient.

Pharmacologic rationale for RAAS dual blockade

Dual blockade of the RAAS is a very appealing therapeutic option from a mechanistic standpoint. ACE inhibitors exert their effect through multiple mechanisms including blocking the production of angiotensin II, a potent vasoconstrictor, thereby decreasing aldosterone secretion, which decreases sodium and water retention. In addition to these effects, ACE inhibitors increase the effects of kinins such as bradykinin, which is believed to have a positive effect on cardiac remodeling, fluid loss, and vasodilation.2,3 Interestingly, although angiotensin II production is initially halted with ACE inhibitor therapy, studies have found that levels of angiotensin II return to almost normal levels with prolonged ACE inhibitor therapy.3 This phenomenon of "ACE escape" is believed to be due to alternative enzymatic pathways that convert angiotensin I into angiotensin II.3

Angiotensin II receptor blockers prevent the deleterious effects of angiotensin II by blocking angiotensin II at AT1 receptors.3 This prevents the negative effects of angiotensin II from occurring, while concurrently allowing the theorized positive effects of angiotensin II to continue at the AT¬2 receptor.4 These positive effects include antiproliferative, vasodilatory, and antigrowth effects.4 Due to the fact that ACE inhibitors and ARBs exert their therapeutic effects at different sites of the RAAS, the hypothesis of a synergistic effect has been explored. Ideally, if used in combination, one would maximize the positive effects of these medications through kinins and positive angiotensin II effects. This mechanistic hypothesis has led to a significant amount of research in the area of dual blockade.

Clinical Trials

Clinical trials evaluating RAAS dual blockade regimens in HF have produced mixed results. A thorough literature evaluation provides the perspective that dual blockade may help prevent hospitalization in advanced chronic systolic heart failure, but has minimal effects on mortality and a significant adverse effect profile.3,5 An exhaustive review of all trials is beyond the scope of this article, so emphasis will be placed on some of the major trials.

The Valsartan Heart Failure Trial (Val-HeFT) was one of the early trials to evaluate dual blockade of the RAAS in HF patients. In this study, researchers enrolled patients who were receiving background therapy for HF, which included an ACE inhibitor in approximately 93% of patients, and assigned them to receive valsartan or placebo in addition to their background therapy.6 This trial included 5010 patients and had two primary endpoints, mortality and a combined endpoint of mortality and morbidity.6 Results from this trial demonstrated that the addition of valsartan did not significantly affect death from any cause compared to placebo, but did significantly reduce the combined endpoint of mortality and morbidity. This significant finding was influenced strongly by a decrease in the number of hospitalizations for HF.6 Other pertinent findings included a significant increase in discontinuation of study medication in the treatment group receiving valsartan compared to patients receiving placebo ($p<0.001$).6 Also of interest was the fact that patients receiving valsartan whose background therapy included a beta-blocker and ACE inhibitor experienced a significant increase in mortality and nearly significant increase in morbidity.6 It is important to note that the number needed to treat to prevent one hospitalization in this trial was 22, while the number needed to harm was 37.

The Valsartan In Acute Myocardial Infarction Trial (VALIANT) evaluated the effects of adding valsartan, valsartan plus captopril, or captopril to conventional therapy 0.5 to 10 days post acute myocardial infarction.7 The primary endpoint was death from any cause and was similar in all three treatment groups with no significant differences seen ($p=0.73$).7 These results effectively proved that combination therapy with valsartan and captopril does not decrease mortality post myocardial infarction, but also proved that valsartan was non-inferior to captopril in this population. Another finding of this study came from a post hoc analysis of the data which revealed that the valsartan plus captopril group experienced significantly ($p=0.007$) fewer investigator-reported hospital admissions for heart failure or myocardial infarction compared to captopril alone.7 Similar to the Val-HeFT trial, patients experienced significantly greater adverse events and higher discontinuation rates with combination therapy compared to captopril or valsartan alone.

The Candesartan in Heart Failure Assessment of Reduction in Mortality and Morbidity (CHARM)-Added trial was performed to analyze if adding candesartan to treatment with an ACE inhibitor would be more advantageous than ACE inhibitor monotherapy.8 The study found that combination therapy significantly decreased primary outcomes, cardiovascular death or hospitalization; however, the number of deaths from any cause between the candesartan and placebo groups was not significant ($p=0.086$).8 Overall, more patients receiving candesartan plus ACE inhibitor (309, 24%) discontinued therapy due to adverse effects compared to ACE inhibitor alone (233, 18%) ($p=0.0003$).8 It was also noted that in this trial patients receiving treatment with an ACE inhibitor, ARB, and beta-blocker did not experience the same trend toward increased mortality that was seen in the Val-HeFT study.

Combination Therapy with ACE inhibitors and ARBs in Heart Failure

Continued from page 4

This finding disproved the possibility of ACE inhibitor, ARB, and beta-blocker combination therapy increasing mortality.

Another important trial, Heart failure Endpoint evaluation of Angiotensin II Antagonist Losartan (HEAAL), evaluated if the dose of ARB affected clinical outcomes. Patients enrolled in this trial had systolic HF, intolerance to ACE inhibitors, and were given either a high dose (150 mg) or low dose (50 mg) of losartan daily.9 The overall results of this study indicated that high dose therapy was superior to low dose therapy in reducing the composite endpoint of death or admission for heart failure (p=0.027), with the significant difference being largely influenced by a decrease in hospitalizations.9 Interestingly, patients receiving high dose therapy also experienced significantly more adverse events with an overall 49% increased risk of hyperkalemia and 43 % increased risk of renal impairment.9 These findings indicate that higher ARB doses improve outcomes but come at an increased risk of adverse drug events.

Summary

These studies provide a basis for the current Heart Failure Society of America and AHA guideline recommendations for HF treatment. They also are the foundation on which prescribers must base their decision when determining when it is appropriate to utilize dual blockade therapy. The CHARM-Added and Val-HeFT trials both report similar findings that conclude dual therapy decreases hospitalization, but has no effects on overall mortality.6,8 CHARM-Added shows a significant reduction in cardiovascular mortality, but not all cause mortality. Likewise, Val-HeFT demonstrated significant improvement in the combined endpoint, but again no significant difference in all cause mortality was seen. The VALIANT trial found that post myocardial infarction dual blockade has no mortality benefits either.7 Another central element to all of these studies was the high rate of adverse events associated with ACE inhibitor and ARB therapy.6,7,8 Phillips, et al. performed a quantitative review of data from randomized control trials evaluating the number of adverse effects with dual blockade therapy. This review found significant rates of medication discontinuation due to adverse effects, specifically symptomatic hypotension, worsening renal function, and hyperkalemia.5 T his highlights the difficult nature of determining the risks versus benefits of RAAS dual blockade therapy.

Dual blockade of the RAAS clearly provides some benefit to systolic heart failure patients, mostly in the form of decreased hospitalizations. Unfortunately, this clinical benefit comes at the risk of significant adverse effects. This suggests that ACE inhibitor plus ARB therapy in chronic heart failure may have a role in select patients, but these patients must be selected carefully. Current guideline recommendations reflect this by supporting consideration but not absolutely recommending ACE inhibitor plus ARB therapy in patients with reduced ejection fraction who have persistent symptoms or worsening HF, despite maximal ACE inhibitor and beta-blocker therapy.1 In addition to being selective to which patients receive dual blockade therapy, practitioners must frequently monitor these patients for occurrence of adverse effects. With all of this in mind, practitioners and patients must carefully weigh the risks and benefits of dual blockade therapy in HF.

References

1. Lindenfeld J, Albert NM, Boehmer JP, et al. Executive summary: HFSA 2010 comprehensive heart failure practice guideline. J Card Fail. 2010;16:475-539.
2. Hunt SA, Abraham WT, Chin MH, et al. 2009 Focused Update Incorporated Into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines: Developed in Collaboration With the International Society of Heart and Lung Transplantation. Circulation. 2009;119:e391-e479.
3. Scow DT, Smith EG, Shaughnessy AF. Combination therapy with ace inhibitors and angiotensin-receptor blockers in heart failure. Am Fam Physician.2003;68(9):1795-1798.
4. Gring CN, Francis GS. A hard look at angiotensin receptor blockers in heart failure. JACC. 2004;44(9):1841-1846.
5. Phillips CO, Kashani A, Ko DK, et al. Adverse effects of combination angiotensin II receptor blockers plus angiotensin-converting enzyme inhibitors for left ventricular dysfunction. Arch Intern Med. 2007;167(18):1930-1936
6. Cohn J, Tognoni G, et al. A randomized trial of the angiotensin-receptor blocker valsartan in chronic heart failure. N Engl J Med. 2001;345(23):1667-1675.
7. Pfeffer MA, McMurray JV, Velazquez EJ, et al. Valsartan, captopril, or both in myocardial infarction complicated by heart failure, left ventricular dysfunction, or both. N Engl J Med. 2003;349(20):1893-1906.
8. McMurray JJ, Ostergren J, Swedberg K, et al. Effects of candesartan in patients with chronic heart failure and reduced left-ventricular systolic function taking angiotensin-converting-enzyme inhibitors: the CHARM-added trial. The Lancet. 2003;362:767-771.
9. Konstam MA, Neaton JD, Dickstein K, et al. Effects of high-dose versus low-dose losartan on clinical outcomes in patients with heart failure (HEAAL study): a randomized, double-blind trial. The Lancet. 2009;374:1840-1848.

MOLINA®
Medicaid Solutions

Provider Relations
P.O. Box 91024
Baton Rouge, LA 70821

7553MMS1011

For information or assistance, call us!

Provider Enrollment	(225) 216-6370
Prior Authorization	
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
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
MMIS/Claims Processing/Resolution Unit	(225) 342-3855
MMIS/Recipient Retroactive Reimbursement	(225) 342-1739 1-866-640-3905
Medicare Savings Program Medicaid Purchase Hotline	1-888-544-7996
KIDMED & CommunityCARE AHS	1-800-259-4444
For Hearing Impaired	1-877-544-9544
Pharmacy Hotline	1-800-437-9101
Medicaid Fraud Hotline	1-800-488-2917