Louisiana Medicaid | Provider UPDATE

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Louisiana Receives Approval for Affordable Care Act Enhanced Reimbursement

All Providers

The Affordable Care Act (ACA) requires Medicaid to reimburse designated physicians for specified primary care services rendered during calendar years 2013 and 2014 at an enhanced rate. Physician assistants (PAs) and advanced practice registered nurses (APRNs) may also be eligible for enhanced reimbursement when federal requirements for physician supervision are met. Full disclosure of providers who are eligible for enhanced reimbursement, as well as additional requirements, can be found in the web notice "ATTENTION PRIMARY CARE PROVIDERS: Affordable Care Act Primary Care Services Enhanced Reimbursement Information" posted on www.lamedicaid.com.

The Department of Health and Hospitals (DHH) received approval of the reimbursement methodology from the Centers for Medicare and Medicaid Services (CMS) in June and began paying the enhanced rates for designated physicians and PAs on the June 25, 2013 check write. Enhanced payments to APRNs are targeted for September 2013. The following fee schedules detailing the new rates have been posted on www.lamedicaid.com under the "Fee Schedule" link:

- Immunization Administration – ACA Enhanced Reimbursement Fee Schedule: Age 0 – 18
- Immunization Administration – ACA Enhanced Reimbursement Fee Schedule: Age 19 & Older
- Professional Services – ACA Primary Care Services Enhanced Reimbursement Fee Schedule

A separate amendment detailing the reimbursement methodology for claims paid by the Managed Care Organizations (MCOs) was submitted to CMS, and DHH received approval on July 11, 2013. MCO contract revisions are underway and provider payments are expected to be completed this fall.

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Recovery Audit Contractor Seminar Scheduled

All Providers

The Department of Health and Hospitals and Myers and Stauffer LC are hosting a Provider Education Seminar on Wednesday, September 18, 2013 from 9:00 a.m. to 11:00 a.m. Information about the new Medicaid Recovery Audit Contractor (RAC) program that has been mandated by the Centers for Medicare and Medicaid Services will be presented. The seminar will be held in Room 118 at the Bienville Building, which is located at 628 North 4th Street, Baton Rouge, Louisiana.

Seating for the seminar will be limited; therefore, advanced registration is required. Registration should be made by e-mailing Myers and Stauffer LC at LouisianaRACOutreach@mslc.com. Providers who are not able to be present for the seminar will be able to view it through a live stream at http://new.dhh.louisiana.gov/index.cfm/page/1653.

The seminar will also be recorded and available for future viewing at the Myers and Stauffer LC - Louisiana Medicaid RAC website at LouisianaMedicaidRAC.mslc.com.

Medicaid Changes Effective January 2014

All Providers

Beginning January 1, 2014, changes will be made to the LaMOMS, Medicaid Purchase Plan, and Disability Medicaid programs. Qualifying income limits will be reduced for women applying for Medicaid assistance for pregnancy-related care through the LaMOMS program. Anyone who is currently enrolled in the program, or whose application is received prior to January 1, 2014, will not be affected. Only those applications received on or after January 1, 2014 will be evaluated based on the new eligibility guidelines.

New eligibility criteria will also have to be met for individuals who receive Medicaid through the Medicaid Purchase Plan, often referred to as the "Ticket-to-Work" program. Qualifying income and resource limits will be reduced; however, all life insurance policies, medical savings accounts and retirement accounts will be considered as well as spousal income and resources. The Department of Health and Hospitals anticipates this change will affect nearly 1,200 individuals who are currently enrolled in the program, with 700 of those having Medicare coverage as their primary insurance.

The Disability Medicaid program which provides medical coverage to individuals not receiving Supplemental Security Income (SSI), but who meet certain income and age or disability criteria, will end. Medicaid automatically enrolls individuals who receive SSI cash benefits. Therefore, the more than 9,200 individuals currently enrolled in the Disability Medicaid program have been notified to apply for SSI as soon as possible. Beginning January 1, 2014, applicants will be referred to the Social Security Administration to complete an SSI application if they appear to meet SSI eligibility criteria.

Subsidized health insurance may be available to individuals who no longer qualify for Medicaid through the Federal Health Exchange created through the Affordable Care Act (ACA). Open enrollment for ACA coverage begins October 1, 2013, with coverage available January 1, 2014. To learn more about these options, visit www.healthcare.gov.

Providers are reminded of the importance of verifying the eligibility status of all Medicaid recipients prior to providing services. Failure to confirm eligibility could result in denial of reimbursement for services provided.

Criteria for Wearable Cardioverter Defibrillator Vest Established

All Providers

Louisiana Medicaid has established specific criteria that must be met for recipients requesting a wearable cardioverter defibrillator (WCD) vest. Prior authorization is required for reimbursement of this medically necessary device. Authorization will not be made if the request is for experimental or investigational purposes. Authorization approval will only be considered for recipients who are 18 years of age or older, are at a high risk of sudden cardiac arrest and meet the other specific published criteria.

The fee schedule was updated in April 2013 to include code K0606 (WCD Life Vest) effective October 1, 2008.

Information about the other required criteria can be found on the Louisiana Medicaid website at http://www.lamedicaid.com/provweb1/Recent_Policy/Web_Post_Criteria_for_WCD.pdf. Any questions regarding this change should be directed to Molina Provider Relations at (800) 473-2783 or (225) 924-5040.

Facility Notification System Update

All Providers

The Facility Notification System (FNS) is a web application used by Medicaid providers to submit information electronically to the Department of Health and Hospitals (DHH). This system, which has been charged with improving processing times and reducing operating costs associated with handling paper forms, has a new addition to its continually expanding role. Effective August 2013, the FNS added the Newborn Request form to the electronic forms submission directory.

Electronic submission of the Newborn Request form is not new to most facilities; however, submission through the FNS will now pre-populate certain data fields on the mother of a newborn, and in most cases, will provide next day newborn certifications. Training on the new FNS Newborn Request form for hospital representatives was held via webinar and teleconference. A user guide and training video are also available on the systems website at https://bhsfweb.dhh.louisiana.gov/dhh148.

Individuals who are not already registered to use the FNS should submit a completed "Confidentiality Responsibilities Agreement" form to the Medicaid Eligibility Systems Section to obtain a user name and password. A copy of this form is available at https://bhsfweb.dhh.louisiana.gov/DHH148/Documents/MVA_Form_148E.pdf or by contacting the Medicaid Eligibility Systems Section at 225-342-0706.

Remittance Advice Corner

All Providers

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

Attention Primary Care Providers

On June 6, 2013, DHH received CMS approval for a State Plan Amendment (SPA) authorizing reimbursement of designated physicians for specified primary care services rendered during calendar years 2013 and 2014 at an enhanced rate as required by the Affordable Care Act (ACA). Consistent with the approved SPA, with the June 25, 2013 check write DHH will update the fee schedule and reimburse new claims for eligible services at the enhanced rate. In July 2013, eligible claims paid in previous check writes will be adjusted to reimburse for the difference between the Medicaid rate paid and the enhanced rate required. No action of the part of providers is required.

Attention Pharmacists and Prescribing Providers

Pharmacy claims for sedative hypnotics for shared health plans or legacy recipients will be subject to maximum daily dosage limits effective June 18, 2013. Claims which exceed the maximum daily dose will deny with EOB 529. See http://www.lamedicaid.com/.

Attention Pharmacists and Prescribing Providers

Pharmacy claims for proton pump inhibitors for shared health plans or legacy recipients will still be subject to maximum duration of therapy of 120 days effective July 1, 2013. Claims which exceed the maximum duration of therapy will deny with EOB 697. To continue therapy past 120 days, MDs will need to get prior authorization. See http://www.lamedicaid.com/.

Attention Professional Services Providers

It has been brought to the attention of DHH that some of the fees for the new 2013 HCPCS codes were inadvertently added prior to budgetary reductions. Additionally, revisions have been made to CPT codes 95017 and 95018 to accurately reflect the new descriptions, units, and fees.

The above items have been corrected and the Professional Services Fee Schedule has been updated. All impacted claims will be recycled for potential recoupment and/or adjustment of funds. No action is required by providers.

Scheduled Claims Recycle for Primary Care Services with Affordable Care Act Enhanced Rates

DHH authorized a special check write scheduled for Wednesday, July 17, 2013, in order to address prior paid claims for specified primary care services rendered by Designated Providers which are eligible for an enhanced rate as required by the Affordable Care Act (ACA). As CMS approved our methodology on June 6, 2013, the ACA enhanced rates were added to the claims processing system on June 17, 2013 and eligible Designated Providers began to see higher payment of these services beginning with the June 25, 2013 check write. The new check write will address claims for dates of service January 1 through June 16, 2013 which were processed before we implemented the enhanced rates into our processing system. EFTs will be released on Thursday, July 18.

Only claims paid under legacy Medicaid or Bayou Health Shared Savings plans (Community Health Solutions of America and United Healthcare) will be affected. DHH requires approval from CMS regarding the methodology to reimburse enhanced rates for the Prepaid Plans.

Physicians whose Designated Physician form was processed and approved by Molina Provider Enrollment prior to June 17, 2013 will be included in the recycle and systematic adjustment of claims. Advanced Practice Registered Nurses eligible for enhanced rate payment will be processed at a later date.

Additionally, providers should review any claims on this check write which deny due to the patient having third-party liability (TPL). They will need to submit the claim to the other insurance first and then submit an adjustment to Molina afterwards in order to receive the enhanced rate, if applicable. For more information related to the ACA enhanced rates and affected providers, please see "ATTENTION PRIMARY CARE PROVIDERS: Affordable Care Act Primary Care Services Enhanced Reimbursement Information" posted to www.lamedicaid.com on June 16, 2013.

Attention ACA Providers:
Second Adjustment to Occur for claims with Service Dates 1/1/13 – 2/19/13

The ACA notice posted below dated 06/18/13 indicates in Question 12 that for dates of service January 1, 2013 through February 19, 2013, rates for E&M services will reimburse at the Medicare rate applicable to the non-facility setting. During the systematic adjust process that occurred on the RA of 07/17/13, claims with these dates of service were incorrectly adjusted to the facility rate. The online ACA Fee Schedule for dates January 1, 2013 through February 19, 2013 also indicates the facility rate instead of the non-facility rate.

A second systematic adjustment of these incorrectly paid claims (service dates January 1st through February 19th) will occur within the next few weeks and the fee schedule will be corrected. Please continue to review the RA messages and web notices as you will be notified when this second recycle occurs. We apologize for any inconvenience this has caused.

Attention ACA Providers:
Adjustment of 7/17 Check Write

Providers were notified that the ACA enhanced rates adjustments which were reflected on the 07/17/13 RA were incorrectly priced at the facility rate. This only affected certain claims with dates of service 01/01/13 through 02/19/13. The rates have been updated in our claims system to reflect the non-facility rate, and you will see these adjustments on the 07/30/13 RA.

Attention Louisiana Behavioral Health Providers

Currently all Behavior Health claims from Medicare (Crossover Claims) are being denied for edit 555 (SUBMIT CLAIM TO LBHP SMO) indicating that the claims should be submitted to Magellan for payment. Effective with the August 6, 2013 Date of Payment, Medicare Crossover Claims will be denied with new edit 133 (BEHAVIORAL HEALTH CROSSOVER SENT TO SMO (MAGELLAN)). Molina will automatically forward these claims to Magellan for appropriate processing. Once this new edit is in place, no action will be required by the providers. (CMHC providers are excluded from this process and claims will continue to be processed by Molina.)

If you have questions or concerns, please contact Lou Ann Owen at (225) 342-1353, or LouAnn.Owen@LA.GOV.

Attention Dental Providers

Effective for dates of service on and after August 1, 2013, changes will be imposed for the Dental

Remittance Advice Corner - *Continued*

All Providers

Programs including reimbursement changes and revised policy. Implementation of these changes may be delayed if required programming changes are not complete; however, if this occurs, Medicaid will recycle affected claims. Complete details will be placed on the www.lamedicaid.com website under the 'Dental Providers', and 'Fee Schedule' links. If you have questions, you may contact the LSU Dental Medicaid Unit at 504-941-8206 or 1-866-263-6534 (toll-free).

Attention Hospital Providers

It has been brought to the Department's attention that the fee schedules for outpatient hospitals had an incorrect indicator displaying. The fee schedules incorrectly indicated that reimbursement for some procedure codes were being limited to crossover claims only. This was an error on the fee schedules that is being fixed. Claim reimbursement was not impacted by this error therefore no recycle/ resubmission of claims is needed.

Attention Pharmacists and Prescribing Providers

Pharmacy claims for shared health plan or legacy Medicaid recipients for combination acetaminophen products will continue to deny when the dose of acetaminophen exceeds four (4) grams per day; claims for combination aspirin products will still deny when the dose exceeds six (6) grams per day. Dosing will be accumulated from all active prescriptions. The denial cannot be overridden through Point of Sale claims processing.

Attention Providers with Erroneously Denied or Pended Claims on July 30, 2013
RA Edits 043, 190, 200 and 201

On the check write dated July 30, 2013, we experienced a claims processing issue involving claims requiring prior authorization. This caused some erroneous claim denials and pends. The identified edits associated with these incorrect denials are 043, 190, 200 and 201.

We will reprocess these claims on the provider's behalf and will enter them into the claims processing system with a new Internal Control Number (ICN) in order to capture the correct Prior Authorization number as originally submitted on the claim. These reprocessed claims will not pend for pre-pay review. Original claims and adjustments/voids will be included. They will be adjudicated in the check write dated August 6, 2013.

Claims related to this error that are pending for edit 190 (PA Number Not on File) and appear in the "Claims in Process" section of the July 30th RA are being reprocessed with a new ICN. However, the pended claims with erroneous PA numbers will continue to pend until they are systematically released. Since we are also reprocessing these claims as original claims, you may see edit 190 denials in the remittances of August 6th or August 13th as these claims move through the system to final adjudication.

Please reconcile your claims against the reprocessed claims from the August 6th RA. If other claims appear to have been denied due to this processing error or due to provider billing error, please resubmit any outstanding claims.

We regret any inconvenience this error has caused.

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)

Online Medicaid Provider Manual Chapters - *Continued*

All Providers

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
General Information and Administration	Section 1.5 – Benefits for Children and Youth	06/14/13
FQHC	Table of Contents Section 22.0 – Overview Section 22.1 – Covered Services Section 22.2 – Provider Requirements Section 22.4 – Reimbursement	06/20/13
Professional Services	Section 5.1 – Covered Services – "Incident To" Services	06/26/13
	Section 5.1 – Covered Services – Exclusions and Limitations	07/15/13
Hospital Services	Table of Contents Section 25.3 – Outpatient Services Section 25.8 – Claims Related Information	07/15/13
RHC	Table of Contents Section 40.0 – Overview Section 40.1 – Covered Services Section 40.2 – Provider Requirements Section 40.4 – Reimbursement	07/24/13
FQHC	Table of Contents Section 22.2 – Provider Requirements	07/25/13

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	
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	

Assessing Asthma Control and Appropriate Use of Relief Inhalers

Louisiana Drug Utilization Review (LADUR) Education

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Introduction

According to data from the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS) survey in 2010, 13.8% of adults in the United States had been diagnosed with asthma in their lifetime.[1] In a follow-up call-back survey of those with asthma, 52.4% reported having an attack in the previous year.[2] In Louisiana, 11.6% of respondents reported an asthma diagnosis in their lifetime and in the call-back survey, 60.3% reported an asthma attack in the previous year.[2,3]

Asthma is a costly disease, especially when uncontrolled. Uncontrolled asthma leads to multiple exacerbations, which often result in increased medication and hospitalization costs. In a period from 2002 to 2007, it was estimated that yearly asthma-related medical costs in the US were approximately $3300 for each person diagnosed with asthma.[4] By regularly assessing asthma control and encouraging proper use of inhalers, practitioners can help patients better manage their asthma and decrease exacerbations.

In the Expert Panel Report-3:Guidelines for the Diagnosis and Management of Asthma (EPR-3) released in 2007 by the National Heart, Lung, and Blood Institute's National Asthma Education and Prevention Program (NAEPP), four essential components of asthma management are recommended.

The four components of asthma management include:

- Measures of assessment and monitoring-obtained by objective tests, physical examination, patient history and patient report to diagnose and assess the characteristics and severity of asthma and to monitor whether asthma control is achieved and maintained
- Education for a partnership in asthma care
- Control of environmental factors and comorbid conditions that affect asthma
- Pharmacologic therapy[5]

Assessing Asthma Control

As one of the four components of asthma management, level of control should be routinely assessed for all patients with asthma. The most recent version of the asthma guidelines, EPR-3, placed an increased emphasis on the assessment of asthma control in the ongoing management of patients with asthma. This assessment is used to determine what therapy adjustments, if any, are needed. Based on available evidence, the panel recommended a composite list of elements that define asthma control (See Table 1).

Determining a patient's level of control based on these factors can be accomplished, in part, by using a patient questionnaire. Several scientifically validated instruments for asthma assessment and monitoring are mentioned in the Guidelines and are available in print or online (See Table 2).

Using the results of these instruments, along with patient history and pulmonary function tests, the patient's level of control can then be determined using the age-appropriate classification charts provided in the Guidelines. The levels of asthma control are defined by the EPR-3 as well-controlled, not well-controlled, or very poorly controlled. Assessments of asthma control assist the practitioner in deciding what, if any, adjustments need to be made to therapy. These classification charts are available at www.nhlbi.nih.gov/guidelines/asthma/.

Another patient-friendly assessment strategy, known as the "Rules of Two," was developed by Baylor University Medical Center, and is based on national guidelines for managing patients with persistent asthma. By answering 4 simple questions, a patient can quickly provide information about asthma control. Answers to these questions can provide a basis for discussion between the patient and the practitioner, who can then determine if additional medication or change in medication might be needed to achieve better asthma control.

Rules of Two®

- Do you have asthma symptoms or use a quick-relief inhaler more than two times a week?
- Do you wake up at night with asthma more than two times a month?
- Do you refill your quick-relief inhaler more than two times a year?
- Do you measure your peak flow at less than two times 10 (20%) from baseline with asthma symptoms?

Answering yes to one or more of the above questions indicates a possible lack of asthma control and follow-up with a healthcare provider is recommended for further evaluation and possible adjustment of controller medications.[6]

*Rules of Two® is a federally registered service mark of Baylor Health Care System. ©2011 Baylor Health Care System.

Appropriate Use of Relief Inhalers

One important aspect of assessing asthma control is tracking the patient's use of inhaled short-acting beta 2-agonists (SABAs) or "relief" inhalers. Although SABAs are recommended as the drug of choice for the treatment of acute asthma symptoms, these inhalers are not intended to be used on a regular basis for control of asthma. The only exception to this is the use of SABAs for prevention of exercise-induced bronchospasm (EIB). In patients with asthma who do not have EIB, regular use of SABAs more than 2 days per week for symptom control suggests inadequate control of asthma and the need for initiating or adjusting controller medication.[5]

The use of SABAs as a marker for disease control was suggested following a matched case-control study in 1992 that showed an increased risk of death or near-death from asthma in patients with regular use of inhaled beta 2-agonist bronchodilators.[7] Although this study did not show whether SABAs are directly responsible for this increased risk, results suggested that the use of more than one SABA canister during a one-month period indicated uncontrolled or worsening asthma.[5]

Patient asthma education which encourages self-management techniques can help achieve better overall asthma control. Patients should understand appropriate use of relief inhalers and demonstrate proper inhaler technique. In addition, patients must also recognize lack of asthma control and/or worsening asthma and must know when to seek medical care, especially when frequent use of SABAs is required.[5]

Conclusion

Regular assessment of asthma control is a key component of managing patients with asthma. Several questionnaires and assessment tools are available to assist practitioners in fully assessing a patient's asthma control. Once the level of control has been established, the practitioner can modify the therapeutic regimen to achieve better overall asthma control and to improve quality of life for the patient.

Assessing Asthma Control and Appropriate Use of Relief Inhalers - *Continued*

Table 1

Recommended definition of asthma control[5]	
Reduce impairment • Prevent chronic and troublesome symptoms (e.g., coughing or breathlessness in the daytime, in the night, or after exertion) • Require infrequent use (≤2 days a week) of SABA for quick relief of symptoms • Maintain (near) "normal" pulmonary function • Maintain normal activity levels (including exercise and other physical activity and attendance at work or school) • Meet patients' and families' expectations of and satisfaction with asthma care	**Reduce risk** • Prevent recurrent exacerbations of asthma and minimize the need for ED visits or hospitalizations • Prevent progressive loss of lung function; for children, prevent reduced lung growth • Provide optimal pharmacotherapy with minimal or no side effects

Table 2

Asthma assessment and monitoring tools[5, 9]
Asthma Therapy Assessment Questionnaire© (ATAQ) • Questionnaires for adults (≥ 18 years old) and children (5-17 years old) • Available in English or Spanish • Available as online questionnaire or PDF for printing • Available at http://www.asthmacontrolcheck.com
Asthma Control TestTM (ACT) • Questionnaires for adults (≥12 years old) and children (4-11 years old) • Children's questionnaire includes questions for the child that include a visual scale to help them classify symptoms and a section of questions for the parent/guardian. • Available at http://www.asthmacontroltest.com/
Asthma Control Questionnaire (ACQ) • Clinicians and academicians using the questionnaire in non-commercial clinical practice or research can request paper questionnaire packages free of charge. • Access to interactive web-based version requires registration and user fee • Available at http://www.qoltech.co.uk/acq.html
Asthma Control Score • Easy-to-use scoring system based on a percentage score in 3 areas: clinical, physiological, and inflammatory assessment • Available at http://dlestjournal.chestpubs.org/data/Journals/CHEST/21985/2217.pdf
CAUTION: The sample questionnaires in this table assess only the impairment domain of asthma control and NOT the risk domain. Measure of risk, such as exacerbations, urgent care, hospitalizations, and declines in lung function, are important elements of assessing the level of asthma control.

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Provider Enrollment	(225) 216-6370
Prior Authorization	
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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
For Hearing Impaired	1-877-544-9544
Pharmacy Hotline	1-800-437-9101
Medicaid Fraud Hotline	1-800-488-2917