Louisiana Medicaid | Provider UPDATE

Volume 30, Issue 9 | September / October 2013

Payment Error Rate Measurement Begins

All Providers

The Improper Payments Information Act of 2002 directs Federal agency heads to report improper payment estimates to Congress on programs that are susceptible to payment errors. The Office of Management and Budget (OMB) has identified Medicaid and the Children's Health Insurance Program (CHIP) as programs at risk for significant payment errors. In response to this requirement, the Centers for Medicare and Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) Program to measure the accuracy of these programs.

CMS uses contractors to measure improper payments in Medicaid and CHIP by reviewing a sample of claims along with supporting medical records based on a three year state rotation. Effective October 1, 2013, Louisiana began participating in the PERM cycle for federal fiscal year 2014.

Providers in the sample will be contacted by the PERM contractor, A+ Government Solutions, Inc., who will explain the purpose of the call and CMS's right to collect medical records for audit purposes, and to request identification of the appropriate point of contact for each provider. After confirming that the correct provider has been reached and the necessary medical records have been identified, a written request is sent to the provider specifying the type of documents needed and the instructions on how to submit records to them.

Providers have 75 calendar days to submit the information after receipt of the written request. A+ Government Solutions, Inc. may request additional documentation if the documentation submitted is insufficient to support the claim. Claims with no documentation or insufficient documentation will count against the state as an error. It is important that all sampled providers cooperate with A+ Government Solutions, Inc. and submit all requested documentation in a timely manner to avoid possible sanctioning by Louisiana Medicaid.

Reminder: Even though a provider is no longer doing business with Louisiana Medicaid, under the terms of the Medicaid Provider Enrollment Agreement, recipient records must be retained for five years.

For more information on PERM and your role as a provider, please visit the Provider link on the CMS PERM website at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Providers.html or contact Deanie Vincent, your state PERM representative, at (225) 219-4279 or Deanie.Vincent@la.gov.

Table of Contents

Louisiana Nurse Aide Registry

All Providers

The Louisiana Nurse Aide Registry maintains the names, certification status and work history of individuals who are currently working as a certified nursing assistant (CNA) as well as those whose certification has lapsed due to lack of work history. CNAs lose their certification if they have not performed paid, nursing or nursing related duties for at least eight hours within a 24 month period. It is therefore critical that the data maintained by the registry be accurate. Inaccurate data can impact an individual's ability to work and also affects providers and clients who are dependent on a qualified work force.

Providers who are licensed by the Department of Health and Hospitals that employ CNAs should advise them to check their current certification status on the Registry at www.labenfa.com. CNAs should also verify that all time worked for each employer, is listed under "employment history" at: https://bhsfweb.dhh.louisiana.gov/LARS/Views/Public/LogIn.aspx. If there is missing employment information, the CNA should contact the past employer and request verification of the time worked be sent to the Louisiana Nurse Aide Registry.

Questions regarding certification status or work history should be directed to the Louisiana Nurse Aide Registry at (225) 295-8575.

Nursing Home Program Errors Identified in Review

Nursing Facility Providers

The Centers for Medicare and Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program to comply with the requirements of the Improper Payments Information Act of 2002. CMS uses a 17-state rotation so that each state's Medicaid program is reviewed once every three years for improper payments. As a result of the latest PERM review for Louisiana, only four errors were identified in the nursing home program. One identified error was for insufficient documentation, and the other three errors were for policy violations.

Although Louisiana received an exemplary review, nursing home providers should note that it is imperative that case documentation be complete and made within required time frames. For example, when a doctor or physician assistant visit is made, specific notation must be made in the record to indicate the date of the visit, the time of the visit and who made the visit. Attention to this detail should address recurrence of future errors.

State Medicaid Fraud Recovery Rates Released

All Providers

Through the efforts of the Department of Health and Hospitals (DHH) and the Office of Attorney General, Louisiana had the highest rate of recovery of Medicaid dollars spent per state for fiscal year 2012. According to figures from the Centers for Medicare and Medicaid Services, Louisiana recovered more than $124 million in criminal and civil penalties for fraudulent payments and ranked fifth in the nation for total recovery amounts.

The Medicaid Program Integrity division within DHH recouped more than $4.5 million administratively and made 186 referrals for further investigation to the Office of Attorney General's Medicaid Fraud Control Unit (MFCU) last fiscal year.

The Program Integrity division has recently been restructured and improvements are being made to the methodology and technology that is used to search for and identify overpayments or fraudulent payments. William Root, a former Assistant Special Agent in charge of the Office of Investigations at the United States Department of Health and Human Services, was named as the DHH Inspector General and Chief Compliance Officer. "We are focused on improving how we identify fraud both within our organization, if it exists, and within the state through the use of technology and intelligent design of our fraud identification systems," said Mr. Root. "We have to send a strong signal to those who believe they can wrongfully profit off of the Medicaid system and steal tax dollars from Louisiana's residents. We will not tolerate fraud; it's as simple as that."

The complete 2012 report can be found at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2012-statistical-chart.htm.

Medicaid Changes Effective January 2014

All Providers

Beginning January 1, 2014, changes will be made to the LaMOMS, Medicaid Purchase Plan (MPP), Disability Medicaid, and the Greater New Orleans Community Health Connection programs. Qualifying income limits will be reduced from 200 percent of the Federal Poverty Level (FPL) to 133 percent 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. Those who are currently enrolled will continue to get coverage through the end of the second month following the end of their pregnancy. 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 will reduce from 250 percent FPL to 100 percent FPL, and income and resources for spouses, previously not considered to determine eligibility, will count beginning January 1, 2014. Additionally, the resource limit will reduce from $25,000 to $10,000, and all life insurance policies, medical savings accounts, and retirement accounts will no longer be disregarded. The Department of Health and Hospitals (DHH) 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.

The Greater New Orleans Community Health Connection (GNOCHC) program provides coverage to individuals who meet program and income guidelines and live in the parishes of Orleans, St. Bernard, Plaquemines and Jefferson. Recipients may only receive services from providers who are enrolled in the Community Health Connection network. Effective January 1, 2014, income limits for the program will be reduced from 200 percent of the FPL to 100 percent FPL. DHH anticipates this change will affect nearly 14,000 individuals.

Medicaid enrollees in the MPP, GNOCHC and Disability Medicaid programs will receive notification of these changes by direct mail. Medicaid is working with providers, the Bayou Health Plans and other partners to ensure eligible pregnant women are informed of the changes and are encouraged to apply prior to the December 31 deadline. Any questions about these changes should be directed to the Medicaid Customer Service Hotline at 1-888-342-6207. Updates also can be found at www.medicaid.la.gov. Medicaid providers will receive updates through Remittance Advice notices and web updates at www.MakingMedicaidBetter.com.

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 began 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.

Remittance Advice Corner

All Providers

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

Attention Providers

Starting July 18, 2013, a notice was posted on Molina's web site and in RA messages from Molina informing providers that effective 8/6/2013 (date of payment), Medicare crossover claims for Behavioral Health services would be denied with new edit 133 and the claims would automatically be sent to Magellan for processing. We are notifying you that there is a delay in the automatic transfer, but that it will occur, just at a point toward the end of this month or early in September. Providers will continue to see these denials (edit 133) in Molina's processing system, and all of these claims (with payment date 8/6/2013 and after) will be transmitted to Magellan. No action is required on the part of the provider. We apologize for any inconvenience this may cause.

Attention Pharmacists and Prescribing Providers

Effective September 1, 2013 Louisiana Medicaid will reimburse enrolled pharmacies for the 2013-2014 influenza vaccines and administration of the vaccines for recipients who are nineteen years and older when the administering pharmacist is an enrolled Medicaid provider. The cost of the vaccine will not be reimbursed for recipients under the age of nineteen as these vaccines are available through the Louisiana Vaccines for Children (VFC) program. Only the administration fee will be reimbursed for these recipients. See http://www.lamedicaid.com/.

Attention Electronic Billers/Submitters of Institutional Claims

We want to remind providers and submitters that the following Bill Type codes are the only codes that are acceptable for the Louisiana Medicaid Program, including Bayou Health claims and encounters. The file extension of the electronic claim file is also very important in combination with the Bill Type codes.

For **file extension 837I – UB9** the acceptable Bill Type codes are: 11X, 12X, 13X, 14X, 18X, 71X, 72X, 76X, 81X, 82X, 83X, 85X, 86X; 89X.

For **file extension 837I – HOM** (Home Health) the only acceptable Bill Type code is 33x. When billing Home Health claims electronically you must use the file extension 837I – HOM.

For **file extension 837I – LTC** (Long Term Care) the only acceptable Bill Type codes are: 21X, 65X, 66X. These codes are ONLY acceptable for Long Term Care billing. Hospitals may not use these codes.

Electronic 837I billing files that are submitted with Bill Type codes not included in those listed above **will be rejected** and not entered into the claims processing system. One of the most common errors identified for file rejections is the use of Bill Type 33x with file extension 837I-UB9.

Providers must review the billing instructions for their provider type to ensure use of acceptable Bill Types for their program. Providers using a Bill Type from the list above, that is not acceptable for the specific provider type/medical program, will receive a denial of 042 – Invalid UB Bill Type.

Update to "ClaimCheck" Product Editing

Effective with the Remittance Advice of September 3, 2013:

McKesson's 'ClaimCheck' product is routinely updated by the 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 & 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. The edit changes will affect claims processed beginning with the remittance advice of September 3, 2013. Providers may notice some differences in claims editing as most claims will continue to edit in the same manner but when applicable, claims may now pay or deny for a different reason. Providers will continue to be notified when routine updates are made in the future.

For questions related to this information, please contact Molina Medicaid Solutions Provider Services at (800) 473-2783 or (225) 924-5040.

Continued ACA Enhanced Reimbursement Claims Recycles and Implementation of Enhanced Payments for APRNS

Pursuant to the claims payment logic implemented in June 2013, Molina will recycle previously paid, specified primary care service claims provided by Designated Physicians and eligible Physician Assistants in order to allow the enhanced payments as directed by the Patient Protection and Affordable Care Act. The recycles will cover the following:

- Providers whose Designated Physician forms were processed in late June but eligible for enhanced payments for dates of service beginning 01/01/2013. These providers did not have their claims recycled during July to receive the enhanced rate.
- Additional claims with dates of service 01/01/2013-02/19/2013 which were paid at the incorrect facility rate.

In addition, new claims payment logic was implemented in mid-August to allow Advanced Practice Registered Nurses to receive enhanced rates. However, the majority of claims that are potentially eligible for enhanced payment did not have a referring provider ID on the claim. DHH will post ACA enhanced reimbursement information to the provider manual in the near future. To help facilitate providers receiving the enhanced rates, please note the following:

- Claims submitted via CMS 1500 (paper) require that a valid Designated Physician's NPI be listed on item 17b - Referring Provider.
- Claims submitted via v5010 837P (electronic) require that the Designated Physician's NPI be listed in a NM1 segment with the Qualifier DN. The NMl segment may be billed at either the Claim level 2310A or the Line l evel 2420F.

Claims for APRNs that do not have the Designated Physician listed as the referring provider on their claims will not receive the enhanced rate, nor will previously paid claims be recycled without this critical piece of information.

Providers should submit an adjustment for APRN claims that did not have the required Designated Physician's NPI included in the appropriate location on the previously paid claim. This can

Remittance Advice Corner - *Continued*

be done by paper using the 213 Adjustment Form or electronically via the 837P adjustment format. The Designated Physician's NPI must be entered correctly on the adjustment as indicated above for either paper or EDI adjustments in order to receive the enhanced payment.

Attention Louisiana Behavioral Health Providers Update to the Notice Dated 8/15/13 Concerning New Edit 133 for Behavioral Health Crossover Claims

In July, you were notified that effective 8/6/2013 (date of payment), Medicare crossover claims for Behavioral Health services would be denied with new Edit 133 and the claims would automatically be sent to Magellan for processing. In August, you were notified of a delay in the automatic transfer of these claim s until late August or September.

This notice is to convey another delay in this transfer process. DHH and Magellan are working to resolve the outstanding issues to allow these claims to be processed by Magellan in a timely manner.

Providers will continue to see Edit 133 denials in Molina's processing system, and all of these claims (with payment date 8/6/2013 and after) will be appropriately processed by Magellan as quickly as possible. As before, no action is required on the part of the provider.

We apologize for any inconvenience this may continue to cause as we work to through the final steps in this new process.

Attention Pharmacists and Prescribing Providers of Bayou Health Shared and Legacy Plans:

Effective October 1, 2013, short-acting beta$_2$ agonist inhalers (albuterol, levalbuterol, and pirbuterol) will have a quantity limit of six inhalers per calendar year. Pharmacy claims for omalizunab (Xolair ®) will require a valid ICD-9-CM diagnosis code and a minimum age of 12 years. See http://www.lamedicaid.com/ for more information.

Attention Pharmacists and Prescribing Providers

Effective October 1, 2013 pharmacy claims for concurrent use of different Short-Acting Beta2 Agonis inhalers (SABAs) will deny with a therapeutic duplication (EOB 482). See www.lamedicaid.com for more information.

Bilateral Procedures: Billing Clarification Update

As indicated in the Remittance Advice messages dated July 24-August 7, 2012, when billing for bilateral procedures performed during the same session (unless otherwise directed in CPT), providers are to use the -50 modifier (Bilateral procedure) with the appropriate CPT code and place a "1" in the units field of the claim. The site specific modifiers 'LT' (Left side) or 'RT' (Right side) may be used on appropriate CPT codes only when services are performed on either the right OR the left side. Providers should not use the 'LT' and 'RT' modifiers on the same procedure code instead of the -50 modifier.

Claims processing is being updated to look for and deny inappropriately billed bilateral procedures. Providers can soon expect to see claims denied with error codes 707 and 710 when billed incorrectly.

- 707- Bilateral-Resubmit with modifier 50-One Unit
- 710- Bilateral-Void Paid Claim-Resubmit with Modifier-50

Overpayments due to fragmented claim submissions are subject to review and recovery of the overpayment.

For questions related to this clarification, please contact Molina Medicaid Solutions Provider Services at (800) 473-2783 or (225) 924-5040.

Attention LTC-PCS Providers

Due to programming changes implemented October 1, 2013, claims for procedure codes T1019, TOS 19 with modifiers UB, UN & UP were incorrectly denied with error code edit 210 (PROVIDER NOTCERTIFIED FOR THIS PROCEDURE) claims.

These claims will be systematically corrected, recycled and paid by October 22, 2013.

Claim denials with error code edits 210 (PROVIDER NOTCERTIFIED FOR THIS PROCEDURE) will receive an override for edit 241 (CLAIM HELD FOR PRE-PAYMENT REVIEW) in order to allow those claims to be recycled and paid by the October 22, 2013

Remittance Advice. NO ACTION IS REQUIRED ON THE PART OF THE PROVIDER. We apologize for any inconvenience this may have caused.

For questions related to this notification, please contact Molina Medicaid Solutions Provider Services at (800) 473-2783 or (225) 924-5040.

OB Providers: New NCCI Edits on Codes H0049 and H0050 (Alcohol and/or Drug Screening/Brief Intervention)

The next update to the National Correct Coding Initiative (NCCI) edits may result in the denial of HCPCS codes H0049 (Alcohol and/or Drug Screening) and H0050 (Alcohol and/or drug services, brief intervention per 15 minutes). NCCI editing considers them to be incidental to Evaluation and Management services.

It is the intent and policy of Louisiana Medicaid to continue to reimburse for H0049 and H0050. When these services are appropriately performed on the same date of service as Evaluation and Management services (E/M), the E/M service may be submitted with modifier 25. Documentation in the clinical record must substantiate each service.

There has been no change in policy regarding the use and frequency of H0049 and H0050. These codes are only reimbursable when billed with modifier -TH and reimbursement for these services is restricted to once per pregnancy.

For questions related to this clarification, please contact Molina Medicaid Solutions Provider Services at (800) 473-2783 or (225) 924-5040.

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
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)

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
Medical Transportation	Section 10.2 – NEMT – Service Access/Authorization	08/21/13
Professional Services	Table of Contents Section 5.1 – Affordable Care Act – Primary Care Services Enhanced Reimbursement Appendix A – Contact Information Appendix H – ACA Enhanced Reimbursement Place of Service Codes	09/13/13
Dental Services	Section 16.5 – EPSDT – Covered Services Section 16.7 – EPSDT – Prior Authorization Section 16.8 – Adult Denture Program-Recipient Eligibility Requirements Appendix A – EPSDT Dental Program Fee Schedule Appendix B – Adult Denture Program Fee Schedule Appendix E – Dental Periodicity Schedule Appendix H – Prior Authorization (PA) Sample Letter	09/15/13
Medical Transportation	Section 10.3 – NEMT – Provider Requirements	09/15/13

Online Medicaid Provider Manual Chapters - *Continued*

Manual Chapter	Section(s)	Date of Revision
Pharmacy Services	Table of Contents Section 37.3 – Medicaid Recipient Eligibility Section 37.6 – Reimbursement for Services Frequent Contact Information Appendix A Appendix A-1 Appendix B Appendix C Appendix D Appendix E-1 Appendix E-2 Appendix F Appendix G Appendix H Appendix I Appendix J Appendix K Appendix L	09/18/13
Vision (Eye-Wear) Services	Table of Contents Section 46.2 – Recipient Requirements Appendix A – Fee Schedule Appendix B – Prior Authorization Form	09/19/13
Professional Services	Appendix G – Podiatry Codes	09/20/13
Hospital Services	Section 25.2 – Inpatient Services Section 25.7 – Reimbursement Appendix B – Contact/Referral Information	09/25/13

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	

Review of Recommendations for Use of Palivizumab

Louisiana Drug Utilization Review (LADUR) Education

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Introduction

Respiratory syncytial virus (RSV) is a common disease of early childhood, affecting nearly all children at least once by the time they reach two years of age. Most infants diagnosed with RSV experience upper respiratory tract symptoms, and 20% to 30% will progress to lower respiratory tract infections such as bronchiolitis and/or pneumonia with their first infection. Most infants in good health who develop bronchiolitis due to RSV do not require hospitalization. However, most of those that are hospitalized are discharged within 5 days after receiving supportive care. The American Academy of Pediatrics (AAP) recommendations for the use of palivizumab help to identify those children who are most likely to be at-risk for developing complications caused by RSV, thereby targeting those who would benefit most from prophylaxis with palivizumab. The purpose of this review is to summarize the American Academy of Pediatrics (AAP) recommendations for the use of palivizumab published in the Red Book®: 2012 Report of the Committee on Infectious Diseases (29th Ed).

Review of Recommendations

Palivizumab is a monoclonal antibody available to reduce the risk of lower respiratory tract disease caused by RSV in infants and children with:

- Chronic lung disease of prematurity (CLD-formerly called bronchopulmonary dysplasia) who require medical therapy
- A history of preterm birth (less than 35 weeks gestation)
- Cyanotic or complicated congenital heart disease (CHD), especially conditions causing pulmonary hypertension

Optimal cost benefit from immunoprophylaxis is achieved by administration of palivizumab to at-risk infants and children during peak outbreak months when most RSV hospitalizations occur.

Palivizumab is an intramuscular injection dosed at 15mg/kg once every 30 days during RSV season when prophylaxis is most effective.

Peak RSV activity in North America (with the exception of some communities in Florida) usually occurs between November and March. Initiating prophylaxis too late in RSV season may not provide the full benefit of protection; however, beginning prophylaxis too early or continuing prophylaxis after RSV season has ended is not cost-effective and provides little benefit to recipients. The national average duration of RSV season in recent years has been 19 weeks or less. For infants that qualify for a maximum of 5 doses during RSV season, clinical trials have shown trough serum levels more than 30 days after the fifth and final dose of palivizumab will exceed the protective level for most infants, thus providing protective serum antibody levels for more than 20 weeks.

Palivizumab is not approved, recommended or effective in the treatment of active RSV disease.

Children receiving palivizumab may still experience a breakthrough RSV infection, but monthly prophylaxis should be continued until a maximum number of doses have been administered.

- Infants born at 32 weeks, 0 days through 34 weeks, 6 days gestation qualify for a maximum of up to 3 doses during RSV season.
- Infants without CHD or CLD born before 32 weeks gestation or infants younger than 24 months of age with CHD or CLD qualify for a maximum of 5 doses during RSV season.

Children with CHD who are already on a prophylaxis schedule and undergo procedures using cardiopulmonary bypass should receive a postoperative dose as soon as they are medically stable.

Hospitalized infants who qualify for prophylaxis during the RSV season should receive the first dose of palivizumab 48 to 72 hours before discharge or promptly after discharge.

Infants who have begun palivizumab prophylaxis earlier in the season and are hospitalized on the date when the next monthly dose is due should receive that dose as scheduled while they remain in the hospital.

Palivizumab does not interfere with response to vaccines. All infants > 6 months of age and their contacts should receive influenza vaccine as well as other recommended age-appropriate immunizations.

Infants, especially those at high risk, should never be exposed to tobacco smoke. Though passive tobacco smoke has not been consistently linked with increased risk of RSV hospitalization, exposure to tobacco smoke should be controlled by the family of an infant at increased risk of RSV disease.

Who is "at-risk" and may benefit from RSV prophylaxis with palivizumab?

1. A premature infant born:
   - At or before 28 weeks, 6 days gestation when RSV season occurs during the first 12 months of life
   - At 29 weeks, 0 days to 31 weeks, 6 days gestation if younger than 6 months old at the start of RSV season
   - At 32 weeks, 0 days to 34 weeks, 6 days gestation who are born 3 months before or during RSV season that have at least one of the following risk factors:
     - Infant attends childcare (home or facility care with any number of infants or young toddlers)
     - Infant lives with a child < 5 years of age

   NOTE – These infants should receive doses only until they reach 3 months of age and should receive no more than 3 doses; therefore

Review of Recommendations for Use of Palivizumab - *Continued*

some may receive only 1 or 2 doses until they reach 3 months of age.

2. A child younger than 24 months of age at the start of RSV season who has received treatment with at least ONE of the following for CLD within 6 months before the start of RSV season: supplemental oxygen, diuretics, bronchodilator, or chronic corticosteroid therapy

3. A child up to and including 24 months of age at the start of RSV season who has hemodynamically significant cyanotic or acyanotic CHD is most likely to benefit from prophylaxis if the child:
   - is currently receiving medication to control congestive heart failure
   - has moderate to severe pulmonary hypertension and/or
   - has cyanotic heart disease

4. A child with congenital abnormalities of the airway or a neuromuscular condition that compromises handling of respiratory secretions should receive a maximum of 5 doses during the first year of life

5. A child who is immunocompromised or a child with cystic fibrosis (CF), but limited studies or lack of randomized controlled trials prevent specific recommendations

Who is NOT "at-risk" and does not qualify for RSV prophylaxis with palivizumab?

1. Any child older than 24 months of age at the start of RSV season, regardless of diagnosis

2. A premature infant born:
   - At or before 28 weeks, 6 days gestation who has reached 12 months of age at the start of RSV season
   - At 29 weeks, 0 days to 31 weeks, 6 days gestation who has reached 6 months of age at the start of RSV season
   - At 32 weeks, 0 days to 34 weeks, 6 days gestation who is born before or during RSV season who has reached 3 months of age
   - At 35 weeks gestation or older who DOES NOT have CLD or CHD

3. A child with congenital abnormalities of the airway or neuromuscular condition that compromises handling of respiratory secretions who has reached 12 months of age at the start of RSV season

4. Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus) generally should not receive prophylaxis

5. Infants with cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure

6. Infants with mild cardiomyopathy who are not receiving medical therapy for the condition

Conclusion

Although virtually all children will have had RSV by the time they reach the age of two, only a small percentage of them experience complications serious enough for hospitalization. Since the primary benefit of RSV prophylaxis with palivizumab is to decrease the rate of RSV-associated hospitalizations, healthcare providers can utilize the AAP recommendations to identify infants and young children at greatest risk for developing an RSV infection more likely to lead to hospitalization.

Reference

American Academy of Pediatrics. [Section 3.Summaries of Infection Diseases]. In: Pickering LK, Baker CJ, Kimberlin DW, Long SS, eds. Red Book: 2012 Report of the Committee on Infectious Diseases. Elk Grove Village, IL: American Academy of Pediatrics; 2012

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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
For Hearing Impaired	1-877-544-9544
Pharmacy Hotline	1-800-437-9101
Medicaid Fraud Hotline	1-800-488-2917