

Asthma Management Tools

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Fast Facts about Asthma¹

- According to the Centers for Disease Control and Prevention (CDC), more than 26 million Americans (8.3%) have asthma, over 6 million of which are children.
- Approximately 50% of adults with asthma and 40% of children with asthma do not have their asthma under control.
- There are approximately 1.7 million asthma-related emergency department visits for these patients per year.
- Asthma accounts for more than 500,000 hospitalizations each year and is the 3rd leading cause of children's hospitalization.
- More frequent and intense asthma exacerbations (such as those requiring urgent treatment or hospitalization) indicate poorer asthma control.

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Asthma Medication Ratio

The Healthcare Effectiveness Data and Information Set (HEDIS), a set of indicators developed by the National Committee for Quality Assurance (NCQA), is used to evaluate the quality of healthcare plans and to compare results across different health plans. The Asthma Medication Ratio (AMR) HEDIS measure assesses the quality of asthma care in patients with persistent asthma. The AMR is the ratio of controller medication to the total asthma medication used by a patient.² A study conducted in publically insured children with asthma found that the AMR can be a significant predictor of hospitalizations and emergency department (ED) visits.³ Those with higher AMR values have been shown to have lower rates of asthma-related emergency services than patients with lower AMR values.⁴ For patients with lower AMR values or for those who are either not adherent with their controller medication and/or frequently use their rescue medication, the provider should counsel the patient regarding adherence with the use of their controller medication, proper inhaler technique, and other factors that may result in the more frequent use of their rescue inhaler, such as environmental triggers.

Example:

Jane is prescribed the following: (1) Controller medication, one-month supply x 5 refills and (2) Rescue medication, 1 inhaler for as needed use x 5 refills

After a six-month period, Jane filled her controller medication 2 times and her rescue medication 5 times. Therefore, her $AMR = 2 / (2 + 5) = 0.29$

Jane would benefit from asthma education. Her doctor should discuss controller medication adherence with her; she may not be aware of the importance of her controller medication. Her doctor should also investigate other factors, such as environmental triggers, that may result in excessive use of the rescue inhaler.

Asthma Care Quick Reference⁵

The Guidelines for the Diagnosis and Management of Asthma (EPR-3) was developed by an expert panel coordinated by the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health. These clinical practice guidelines describe a range of best-practice approaches for making clinical decisions about asthma care. See below for a summary of key clinical issues with action steps adapted from these guidelines.

The full report may be accessed at <https://www.nhlbi.nih.gov/health-topics/guidelines-for-diagnosis-management-of-asthma>

Key Clinical Issues and Action Steps
Asthma Diagnosis
<p>Establish asthma diagnosis.</p> <ul style="list-style-type: none"> • Determine that symptoms of recurrent airway obstruction are present, based on history and exam. <ul style="list-style-type: none"> ○ History of cough, recurrent wheezing, recurrent difficulty breathing, recurrent chest tightness ○ Symptoms occur or worsen at night or with exercise, viral infection, exposure to allergens and irritants, changes in weather, hard laughing or crying, stress, or other factors • In all patients ≥ 5 years of age, use spirometry to determine that airway obstruction is at least partially reversible. • Consider other causes of obstruction.
Long-term Asthma Management
<i>Asthma Control</i>
<p>The goal of long-term asthma management is asthma control, which focuses on two domains:</p> <p>Reduce Impairment</p> <ul style="list-style-type: none"> • Prevent chronic symptoms. • Require infrequent use of short-acting beta2-agonist (SABA). • Maintain (near) normal lung function and normal activity levels. <p>Reduce Risk</p> <ul style="list-style-type: none"> • Prevent exacerbations. • Minimize need for emergency care, hospitalization. • Prevent loss of lung function (or, for children, prevent reduced lung growth). • Minimize adverse effects of therapy.
<i>Assessment and Monitoring</i>
<p>Initial visit</p> <ul style="list-style-type: none"> • Assess asthma severity to initiate treatment. <p>Follow-up visits</p> <ul style="list-style-type: none"> • Assess at each visit: asthma control, proper medication technique, written asthma action plan, patient adherence, patient concerns. • Obtain lung function measures by spirometry at least every 1–2 years; more frequently for asthma that is not well controlled. • Determine if therapy should be adjusted: Maintain treatment; step up, if needed; step down, if possible. • Schedule follow-up care. <ul style="list-style-type: none"> ○ Asthma is highly variable over time. See patients: <ul style="list-style-type: none"> ▪ Every 2–6 weeks while gaining control ▪ Every 1–6 months to monitor control ▪ Every 3 months if step down in therapy is anticipated

Use of Medications

Select medication and delivery devices that meet patient's needs and circumstances.

- Use stepwise approach to identify appropriate treatment options.
- Inhaled corticosteroids (ICSs) are the most effective long-term control therapy.
- When choosing treatment, consider domain of relevance to the patient (risk, impairment, or both), patient's history of response to the medication, and willingness and ability to use the medication.

Review medications, technique, and adherence at each follow-up visit.

Patient Education for Self-Management

Teach patients how to manage their asthma.

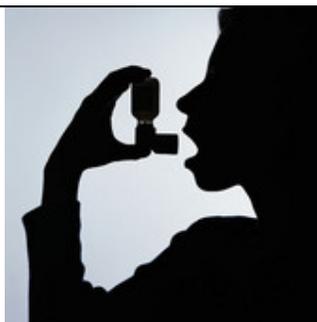
- Teach and reinforce at each visit:
 - Self-monitoring to assess level of asthma control and recognize signs of worsening asthma (either symptom or peak flow monitoring)
 - Taking medication correctly (inhaler technique, use of devices, understanding difference between long-term control and quick-relief medications)
 - **Long-term control medications** (such as inhaled corticosteroids, which reduce inflammation) prevent symptoms. Should be taken daily; will not give quick relief.
 - **Quick-relief medications** (short-acting beta2-agonists or SABAs) relax airway muscles to provide fast relief of symptoms. Will not provide long-term asthma control. If used >2 days/week (except as needed for exercise-induced asthma), the patient may need to start or increase long-term control medications.
 - Avoiding environmental factors that worsen asthma

Develop a written asthma action plan in partnership with patient/family (sample plan available at www.nhlbi.nih.gov/health/public/lung/asthma/asthma_actplan.pdf).

- Agree on treatment goals.
- Teach patients how to use the asthma action plan to:
 - Take daily actions to control asthma
 - Adjust medications in response to worsening asthma
 - Seek medical care as appropriate
- Encourage adherence to the asthma action plan.
 - Choose treatment that achieves outcomes and addresses preferences important to the patient/family.
 - Review at each visit any success in achieving control, any concerns about treatment, any difficulties following the plan, and any possible actions to improve adherence.
 - Provide encouragement and praise, which builds patient confidence. Encourage family involvement to provide support.

Integrate education into all points of care involving interactions with patients.

- Include members of all health care disciplines (e.g., physicians, pharmacists, nurses, respiratory therapists, and asthma educators) in providing and reinforcing education at all points of care.



*Control of Environmental Factors and Comorbid Conditions***Recommend ways to control exposures to allergens, irritants, and pollutants that make asthma worse.**

- Determine exposures, history of symptoms after exposures, and sensitivities. (In patients with persistent asthma, use skin or in vitro testing to assess sensitivity to perennial indoor allergens to which the patient is exposed.)
 - Recommend multifaceted approaches to control exposures to which the patient is sensitive; single steps alone are generally ineffective.
 - Advise all asthma patients and all pregnant women to avoid exposure to tobacco smoke.
 - Consider allergen immunotherapy by trained personnel for patients with persistent asthma when there is a clear connection between symptoms and exposure to an allergen to which the patient is sensitive.

Treat comorbid conditions.

- Consider allergic bronchopulmonary aspergillosis, gastroesophageal reflux, obesity, obstructive sleep apnea, rhinitis and sinusitis, and stress or depression. Treatment of these conditions may improve asthma control.
- Consider inactivated flu vaccine for all patients >6 months of age.

*“Rules of Two®” Method for Determining Asthma Control**

A 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. A patient can quickly provide information about asthma control by answering four simple questions.

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.

Quality asthma care involves not only initial diagnosis and treatment to achieve asthma control, but also long-term, regular follow-up care to maintain control. Achieving and maintaining asthma control requires providing appropriate medication, addressing environmental factors that cause worsening symptoms, helping patients learn self-management skills, and monitoring over the long term to assess control and adjust therapy accordingly.⁵

References

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3. Andrews, A.L., Simpson, A.N., Basco, W.T., & Teufel II, R.J. (2013). Asthma Medication Ratio Predicts Emergency Department Visits and Hospitalizations in Children with Asthma. Medicare & Medicaid Research Review,3(4): E1-E10. <http://dx.doi.org/10.5600/mmrr.003.04.a05>
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6. Hart M.K. & Millard M.W. (2010). Approaches to Chronic Disease Management for Asthma and Chronic Obstructive Pulmonary Disease: Strategies through the Continuum of Care. Proc (Bayl Univ Med Cent),23(3):223-229. Accessed at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2900972/>

Pharmacy Facts

Program Updates from Louisiana Medicaid

June 21, 2018

Cost of Dispensing (COD) Survey

The Department would like to thank all of the pharmacies that participated in the COD Survey. There were 872 responses submitted. Mercer will complete data validation and desk reviews, then the statisticians will calculate the fees. A complete report will be submitted to the Louisiana Department of Health (LDH) by the end of July. LDH will share the final report with stakeholders in August.

Notice of Outstanding Debt and Recovery Efforts

Medicaid Program Integrity (PI) has identified approximately \$23 million in claims-related overpayments, including some pharmacy claims, that Medicaid must make a good faith effort to collect. The dates of service span over 20 years. The common cause for overpayments is claims that have been adjusted or were voided after being paid. LDH collects overpayments by offsetting future submitted claims. However, collection is not possible if providers no longer bill Medicaid fee for service (FFS) under the affected provider number. Common reasons for this happening include movement to billing managed care or a pharmacy provider change of ownership (CHOW), which leads to a new provider number and the old number being closed. Molina now requires a provider to resolve debt before they accept a CHOW application.

As part of Medicaid's good faith effort, 479 letters have been mailed to pharmacies with claims related overpayments. They include:

- Date of service range from calendar year 2000 to the present
- Median negative balance of \$158.13

Each pharmacy affected will receive a letter and a remittance advice (RA) explaining any adjustment. PI is only looking at negative balances with a supporting RA that are available online from 2000 to the present. PI has a dedicated phone number and email address for questions regarding this issue.

Contact info: LDH Medicaid Program Integrity Section: 1-225-219-2575 or via email PI.ARC@la.gov

Single Preferred Drug List Development

The final report from Milliman and Change Healthcare is now being reviewed by Mercer (LDH actuaries), Magellan (LDH supplemental rebate contractor), and the Managed Care Organizations (MCOs). The rulemaking process will begin shortly with a Medicaid notice of intent (NOI) to be published in the Louisiana Register in August 2018. As stated in previous Pharmacy Facts editions, the Department is pursuing the Single PDL as a means of improving the experience of Medicaid recipients, pharmacists and prescribing providers who interact with the Medicaid pharmacy program. Specifically, we aim to overcome the practical challenges faced today with the six different Medicaid drug lists. We appreciate your interest in this development and will continue to provide updates on it through *Pharmacy Facts*: www.ldh.la.gov/pharmacyfacts.

Implementation of New Medicaid Eligibility System Delayed

The implementation of LaMEDS, the state's new Medicaid eligibility and enrollment system, is being delayed with a tentative target date of November. LaMEDS includes a Provider Portal, which replaces the current Facility Notification System (FNS) and allows provider representatives, hospital representatives, and Support Coordination Agency (SCA) reps to submit forms for Medicaid to process. All current representatives authorized to submit forms in FNS will be required to reregister in the new system. Announcements will be posted on the current FNS site in advance of Go Live. Please send all questions to MSMcomm@la.gov

Healthy Louisiana Open Enrollment

The Healthy Louisiana open enrollment period began June 15, 2018 and close July 31, 2018 with enrollment changes becoming effective Sept. 1, 2018.

Enrollees can make changes to their health plan through the Healthy Louisiana mobile app, online at www.myplan.healthy.la.gov or by calling 1-855-229-6848. If enrollees want to keep their current managed care organization (MCO) they don't need to do anything. The member will stay with their MCO for another year, as long as they are still eligible for Medicaid. A flyer containing the open enrollment information for posting in your office may be accessed [here](#).

As a reminder, all health care providers delivering services to Louisiana Medicaid and LaCHIP recipients enrolled in MCOs are welcome to inform their patients of the plans with which they have chosen to participate, but Louisiana Medicaid has strict prohibitions against patient steering, which all providers must observe. Refer to [Informational Bulletin 12-31](#) for more information about the requirements.



Common Hospital Observation Policy

Effective July 1, 2018, all 5 MCOs will adopt a Common Hospital Observation Policy which is detailed below.

Purpose:

This policy outlines how Healthy Louisiana Managed Care Organizations (MCOs) will utilize a common hospital observation policy. This policy has been developed collectively by MCO personnel with approval of the Louisiana Department of Health (LDH). The common hospital observation policy shall be reviewed annually by LDH and the MCOs in its entirety. Any revisions shall be reviewed and approved by LDH at least thirty (30) calendar days prior to implementation of any new or revised language. The purpose of the outpatient hospital services program is to provide outpatient services to eligible Medicaid members and performed on an outpatient basis in a hospital setting. Hospital providers are to ensure that the services provided to Medicaid members are medically necessary, appropriate and within the scope of current evidence based medical practice and Medicaid guidelines.

Definitions:

Business Day- Traditional workdays, including Monday, Tuesday, Wednesday, Thursday and Friday. State holidays are excluded and traditional work hours are 8:00 a.m. – 5:00 p.m., unless the context clearly indicates otherwise.

Observation Time- This begins at the time the order is written to place in observation status or the time a member presents to the hospital with an order for observation, and ends with discharge or an order for inpatient admission.

Observation Care- Is a well-defined set of specific, clinically appropriate services furnished while determining whether a member will require formal inpatient admission or be discharged from the hospital. Observation is for a minimum of 1 hour and up to 48 hours.

- The member must be in the care of a physician during the period of observation, as documented in the medical record by an observation order, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

Observation Procedure:

Healthy Louisiana MCOs will reimburse up to 48 hours of medically necessary care for a member to be in an observational status. This time frame is for the physician to observe the member and to determine the need for further treatment, admission to an inpatient status, or for discharge. Observation and ancillary services do not require notification, precertification or authorization and will be covered up to 48 hours.

Hospitals should bill the entire outpatient encounter, including ED, Observation, and any associated services, on the same claim with the appropriate revenue codes, and all covered services are to be processed and paid separately. Any observation service over 48 hours requires MCO authorization. For observation services beyond 48 hours that are not authorized, MCOs shall only deny the non-covered hours.

If a member is anticipated to be in observation status beyond 48 hours, the hospital must notify the MCO as soon as reasonably possible for potential authorization of an extension of hours. The MCO and provider shall work together to coordinate the provision of additional medical services prior to discharge of the member as needed.

Observation-to-Inpatient Procedure:

Length of stay alone should not be the determining factor in plan denial of inpatient stay/ downgrading to observation stay.

Medicaid members should not be automatically converted to inpatient status at the end of the 48 hours. Admission of a member cannot be denied solely on the basis of the length of time the member actually spends in the hospital.

All hospital facility charges on hospital day one are included in the inpatient stay and billed accordingly inclusive of Emergency Department/observation facility charges. (NOTE: Professional charges continue to be billed separately).

All observation status conversions to an inpatient hospital admission require notification to the MCO within one business day of the order to admit a member. Acceptable notifications include the use of MCOs provider portals, ADT notifications, and other medium through which plans accept clinical communications.

MCOs are prohibited from including any observation hours in the inpatient admission notification period.

The MCO will notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as the member's health condition requires but within no more than one (1) business day of making the initial determination. The MCO will subsequently provide written notification (i.e., via fax) to the provider within two (2) business days of making the decision to approve or deny an authorization request.

If you have any questions, please contact msmcomm@la.gov.



Online Medicaid Provider Manual Chapter Revisions as of June, 2018

Manual Chapter	Section(s)	Date of Revision(s)
Pharmacy Benefits Management Services	37.2 Pharmacy Enrollment and Participation Guidelines	06/15/18
	37.5 Covered Services, Limitations and Exclusions	
Vision (Eyewear) Services	Title Page	06/20/18
	46.1 Covered Services	
	46.2 Recipient Requirements	
	46.4 Prior Authorization	
	46.5 Reimbursement	
	46.6 Record Keeping	
	Appendix A Fee Schedule	
	Appendix C Claims Filing	
Appendix D Contact/Referral Information		

Archived Online Medicaid Provider Manual Chapter Revisions as of June, 2018

Manual Chapter	Section(s)	Date of Omission(s)
Pharmacy Benefits Management Services	37.2 Pharmacy Enrollment and Participation Guidelines	06/15/18
	37.5 Covered Services, Limitations and Exclusions	
Vision (Eyewear) Services	Title Page	06/20/18
	46.1 Covered Services	
	46.2 Recipient Requirements	
	46.4 Prior Authorization	
	46.5 Reimbursement	
	46.6 Record Keeping	
	Appendix A Fee Schedule	
	Appendix C Claims Filing	
Appendix D Contact/Referral Information		

Remittance Advice Corner

Attention Louisiana Fee for Service (FFS) Medicaid Providers

Effective June 26, 2018, pharmacy claims submitted to Fee for Service (FFS) Medicaid for codeine and tramadol containing products will have an age requirement at Point of Sale (POS). Please refer to www.lamedicaid.com for more information.



Attention Louisiana Fee for Service (FFS) Medicaid Providers

Effective June 26, 2018, pharmacy claims submitted to Fee for Service (FFS) Medicaid for nusinersen sodium/PF (Spinraza®) and eteplirsen (Exondys 51®) will have a clinical pre-authorization and diagnosis code requirement at Point of Sale (POS). Please refer to www.lamedicaid.com for more information.



Attention Louisiana Fee for Service (FFS) Medicaid Providers

Effective July 1, 2018, pharmacy claims submitted to Fee for Service (FFS) Medicaid for sacubitril/valsartan (Entresto®) will no longer have a clinical pre-authorization requirement at Point of Sale (POS). Please refer to www.lamedicaid.com for more information.



Attention Louisiana Fee for Service (FFS) Medicaid Providers

Effective July 2, 2018, pharmacy claims submitted to Fee for Service (FFS) Medicaid for Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors: deutetrabenazine (Austedo®), tetrabenazine (Xenazine®), and valbenazine (Ingrezza®) will have a clinical pre-authorization requirement at Point of Sale (POS). Please refer to www.lamedicaid.com for more information.



Attention All Providers

Incorrect Use Of ICD-10 Codes Will Result In Claim Denials

Louisiana Medicaid will be completing the final transition from the ICD-9 Crosswalk to the ICD-10 Code set with date of processing September 4, 2018 forward. Once implemented, ICD-9 codes will no longer be accepted on claims with dates of service 10/1/2015 and after. Below are common provider errors identified during testing that will result in future claim denials.

- Invalid ICD-10 codes
- Header codes sent as ICD-10 codes are non-payable
- ICD-9 codes in ICD-10 fields

Effective September 4th, 2018, Medicaid will implement edits requiring a valid ICD-10 diagnosis code to be reported in the principal diagnosis field. Claims submitted without a valid principal diagnosis code will be denied. The edits will include:

- 433 – Missing/Invalid Diagnosis
- 131 – Primary Diagnosis Not on File
- 132 – Secondary Diagnosis Not on File
- 151---Mixed ICD Code Sets
- 152---Invalid ICD Code on Date of Service

When determining diagnoses, please ensure the diagnosis is applicable for the age and gender of the patient on the billed claim. The age and gender restrictions on the ICD-10 code set are from CMS guidelines and are tighter than currently in the system for the ICD-9 code set.



For Information or Assistance, Call Us!

Provider Enrollment	(225)216-6370	General Medicaid Eligibility Hotline	1-888-342-6207
Prior Authorization:		MMIS Claims Processing Resolution Unit	(225) 342-3855
Home Health/EPSTD – PCS	1-800-807-1320		
Dental	1-866-263-6534		
	1-504-941-8206		
DME & All Other	1-800-488-6334 (225) 928-5263	MMIS/Recipient Retroactive Reimbursement	(225) 342-1739 1-866-640-3905
Hospital Pre-Certification	1-800-877-0666		
Provider Relations	1-800-473-2783 (225) 924-5040	Medicare Savings Program and Medicaid Purchase Hotline	1-888-544-7996
REVS Line	1-800-776-6323 (225) 216-(REVS)7387		
Point of Sale Help Desk	1-800-648-0790 (225) 216-6381	For Hearing Impaired	1-877-544-9544
		Pharmacy Hotline	1-800-437-9101
		Medicaid Fraud Hotline	1-800-488-2917