

Implementation Process Begins for National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard, unique identifiers for health care providers.

The purpose of these identifiers is to improve the efficiency and effectiveness of the electronic transmission of health information. The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers.

As the industry transitions to NPI compliance, remember that there is no charge to get an NPI. You can apply online for your NPI at www.nppes.cms.hhs.gov or call 1-800-465-3203 to request a paper application. The CMS NPI page, www.cms.hhs.gov/NationalProvIdentStand, is the only source for official CMS education and information on the NPI initiative; all products on the site are free.

CMS urges providers to include legacy identifiers

(Continued on Page 2)



Oklahoma Welcomes New SoonerCare Quality Improvement Organization

The Oklahoma Health Care Authority has announced the selection of a new vendor as its Quality Improvement Organization (QIO) for **SoonerCare** (Medicaid). APS Healthcare Midwest (APS) began a three-year contract term July 1, 2006.

This statewide program encompasses prior authorization for behavioral health services, review of health care claims from acute and psychiatric hospitals, and onsite inspections of care for certain behavioral health care providers, among other utilization review and quality improvement services.

APS currently works with 35 public sector programs in 19 states that serve almost one-third of the nation's Medicaid recipients. The APS model views members and their families in the context of the community, treatment

(Continued on Page 3)

in this issue

Clinical News

- 1 Implementation Process Begins for NPI
- 1 Oklahoma Welcomes New SoonerCare Quality Improvement Organization
- 3 O-EPIC Plan Expands to Cover Individuals
- 4 Welcome Extended to New MAC and DUR Members
- 5 Publications for SoonerCare Providers Available on Web
- 5 Oklahoma Bureau of Narcotics Launches Program to Halt "Doctor Shopping"
- 6 Marathon Legislative Session Produces Funding, Reform
- 6 August 2006 Brought Added Safety Features to ePocrates®
- 11 Antibiotic Resistance, Utilization Explored
- 14 Generic Use, Adherence Effective for Patients

Claims / Systems News

- 7 Providers Offered Ways to Avoid Mass Adjustments
- 7 Did You Know?
- 9 PERM Requirements May Prompt Records Requests
- 9 New Periodicity Schedule for Child Health/EPSTD
- 10 SoonerCare Provider Services Introduces New Provider Representatives
- 15 Fall Training Dates Set for Medical, Non-Medical Providers

Implementation Process Begins For NPI (continued from page 1)

(Medicaid provider I.D.s) on their NPI applications, not only for Medicare but for all payors. If reporting a Medicaid number, include the associated state name. If you have already applied for your NPI, CMS asks you to go back into the NPPES and update your information with your legacy identifiers. This information is critical for payors in the development of crosswalks to aid in the transition to the NPI.

Once you have received your confirmation letter from CMS, you may fax it to OHCA at (405) 530-3224. Include your Medicaid provider identification number(s) on the confirmation letter. No cover letter is required.

EDI applications for electronic providers and billing agents, as well the application for the 835 electronic remittance advice, have already been modified to allow for the inclusion of the NPI if available.

NPI and Organizational Subparts

OHCA currently identifies different subparts of organizations by an alphabetical character at the end of the Provider I.D. number. National Provider Identifiers will not allow these alphabetical characters.

If you wish to track different subparts of your organization, you will need to apply for separate NPIs for each subpart. If you do not obtain separate NPIs, you will have no way to track claims or revenue

associated with a particular subpart. The remittance advice (RA) will include all revenues for the NPI, and OHCA will not be able to separate them in any way.

If you need help, contact your provider representative or contact Provider Enrollment at 1-800-522-0114, option 5, or (405) 522-6205, option 5. Guidance from Medicare on obtaining NPIs for subparts is available at www.cms.hhs.gov/NationalProvIdentStand/06_implementation.asp#TopOfPage.

If you obtain separate NPIs for organization subparts, please indicate on your faxed CMS letter which Medicaid provider I.D.s (including the alphabetical letter) are associated with each NPI.

NPI Implementation Timeline

Providers, billing agents, and others should be aware of the following dates in order to make the necessary modifications to their systems and business processes.

10/01/2006 New and renewing contracted providers will be asked to send in their NPI number as part of the contracting process. Projected target date for the CMS-1500.

03/01/2007 The NPI and current provider identification numbers will be required on all claims submitted to the Oklahoma Health Care Authority. NPIs will be required as part of the contracting process.

04/01/2007 (*Tentative date*) All paper claims will need NPI added to the claim form. Additional updates will be added to the Web site as available. Continue to bill your paper claims with your legacy I.D.

05/23/2007 All claims will be submitted with NPI only.

October 2006						
Sun	Mon	Tues	Wed	Thurs	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

March 2007						
Sun	Mon	Tues	Wed	Thurs	Fri	Sat
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

April 2007						
Sun	Mon	Tues	Wed	Thurs	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

May 2007						
Sun	Mon	Tues	Wed	Thurs	Fri	Sat
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

Oklahoma Welcomes New *SoonerCare* Quality Improvement Organization (continued from page 1)

needs, and ability to access and utilize services. APS has pioneered utilization and quality management approaches to maximize access to medically necessary health care services that meet the highest standards of quality.

“We are excited about our new partnership with APS,” said Mike Fogarty, chief executive officer of OHCA. “APS’ strong experience with other Medicaid programs shows that they understand the challenges

that states are facing. I am confident that APS will work with us to ensure that our **SoonerCare** program reaches a high level of excellence.”

APS is located at 4545 Lincoln Blvd., Suite 103, in Oklahoma City. Visit the Oklahoma QIO Web site at www.SoonerPro.com or call APS at (405) 556-9700. The Prior Authorization Hotline can be reached by phone at (800) 762-1560, or fax requests to (800) 762-1639.

“We are excited about our new partnership with APS. APS’ strong experience with other Medicaid programs shows that they understand the challenges that states are facing.”

—Mike Fogarty, CEO of OHCA

O-EPIC Plan Expands to Cover Individuals

The Oklahoma Health Care Authority created the Oklahoma Employer/employee Partnership for Insurance Coverage (O-EPIC) to address the needs of working Oklahomans. O-EPIC has two initiatives: a premium assistance plan for small businesses that began in November 2005 and an upcoming health insurance program called O-EPIC Individual Plan (IP).

O-EPIC IP is a state-administered health insurance plan that extends coverage to:

- Self-employed individuals not eligible for small group health coverage.
- Workers who are either not eligible to participate or whose employers do not offer an O-EPIC Qualified Health Plan.
- The unemployed who are currently seeking work.
- Working individuals with disabilities.

This plan has a limited benefit package with a lifetime benefit maximum. Participants are required to choose a primary care provider, or PCP. The PCP becomes the “medical home,” taking care of basic health care needs and providing referrals to specialists when necessary.

To be eligible for O-EPIC IP, the person must meet certain income, age, citizenship and residency requirements and not currently have an open application for either **SoonerCare** (Medicaid) or Medicare. Premiums will be assessed based on income. While the plan does not have an annual deductible, the member is responsible for co-payments.

For more information regarding the O-EPIC Individual Plan, please visit our Web site at www.oepic.ok.gov or call the O-EPIC helpline at: 1-888-3-OK-EPIC (1-888-365-3742).



Welcome Extended to New MAC and DUR Members

The Medical Advisory Committee (MAC) began a new term on July 1, 2006, and welcomed two new committee members: Heather Kasulis, Au.D., CCC-A., and Robert “Buck” Wright, M.D. Kasulis represents audiology, while Wright was appointed by the Oklahoma Academy of Pediatrics.

MAC assists the Oklahoma Health Care Authority with policy issues and quality standards for the **SoonerCare** (Medicaid) program. The committee advises OHCA on health and medical care services and reviews and makes recommendations on policy development, program administration, policy changes, financial concerns related to the

SoonerCare program and the delivery of health and medical care services. Committee membership is based on statute requirements with regard to the appointment of physicians, who must also be board-certified and participate in the Medicaid program. Other members of the committee represent approximately eight different categories within the community that include, but are not limited to, consumers, hospitals, pharmacists, legislators and others.

The Drug Utilization Review (DUR) Board welcomed new members John Muchmore, M.D., and Mark Feightner, Pharm.D., who also began their terms in July.

The DUR Board advises OHCA on the appropriate and optimal use of pharmaceuticals for Oklahoma Medicaid recipients. The goals of the board are to enhance and improve the quality of drug use through education of physicians and pharmacists in providing the safest and most effective drug therapies. Other areas of board responsibility include policy recommendations regarding medication coverage, restriction of certain classes of medications covered, development and evaluation of the Prospective and Retrospective DUR programs, and establishing the standards for the DUR.

medical advisory committee members

E. Edward Beckham, Ph.D.

Psychology

Bonnie Bellah

Consumer Advocate – Oklahoma Institute for Child Advocacy

Bruce Bennett

Chickasaw National Health System

Steven Buck

Consumer Advocate – National Alliance for the Mentally Ill

Tanya Case

Comanche County Memorial Hospital

Terry Cline, Ph.D.

Department of Mental Health and Substance Abuse

Steven Crawford, M.D.

Family Practice

Mike Crutcher, M.D. – Dr. Edd Rhoades

Designee, Oklahoma State Department of Health

Sherry Davis, A.R.N.P.

Association of Registered Nurse Practitioners

Steve Goforth

Oxford Healthcare

Stanley Grogg, D.O.

Pediatrics

Jo Hill

Consumer Advocate

Ragina Holiman, M.S., C.N.S.

Nursing

Craig Jones

Oklahoma Hospital Association

*Heather Kasulis, Au.D., CCC-A

Audiology

Greg Machtloff

Oklahoma Health Care Association

Dan McNeill, Ph.D.

Oklahoma Academy of Physician Assistants

James Murtaugh, D.D.S.

Dental

Howard Henderick – Sharon Neuwald, Ph.D.

Designee, Oklahoma Department of Human Services

Ann Owen, Ph.D.

Speech and Language Pathology

J. Daniel Post, D.C.

Chiropractic

Jerry Unruh

Long Term Care Association

Steven Walker, D.P.M.

Podiatry

Phillip Woodward, Pharm.D.

Oklahoma Pharmacy Association

*Robert “Buck” Wright, M.D.

Oklahoma Academy of Pediatrics

Travis Yadon, O.D.

Optometry

*Denotes new MAC members.



drug utilization review board members

Dan McNeill, Ph.D., PA-C, Chair

L. Kyle Hrdlicka, D.O.

Clif Meece, D.Ph., Vice Chair

*Mark Feightner, Pharm D.

Dorothy Gourley, D.Ph.

James Rhymer, D.Ph.

Anetta Harrell

Brent Bell, D.O., D.Ph.

*John Muchmore, M.D.

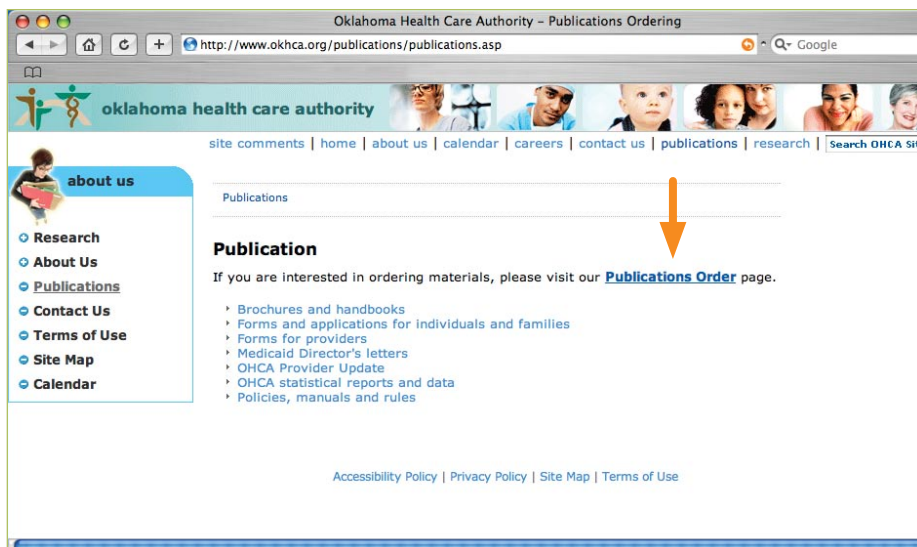
*Denotes new DUR Board members.

Publications for *SoonerCare* Providers Now Available on the Internet

Meaning to call in to the Oklahoma Health Care Authority and request the Summer 2006 Provider Update? Have to call back to get that one manual you forgot to order the first time? Thanks to a new resource for **SoonerCare** providers, there's no need to spend time on the telephone to get the latest and most complete information 24 hours a day, 365 days a year.

OHCA has expanded its Web site to include a host of publications and materials for the **SoonerCare** community. Providers and members can now conveniently click and download brochures and handbooks, forms and applications for individuals and families, forms for providers, Medicaid director's letters, the OHCA Provider Update, statistical reports and data, and policies, manuals and rules.

This user-friendly and well-



www.okhca.org/publications/publications.asp

organized Web site includes all materials that once were available only by calling OHCA and requesting materials to be sent by mail. Providers need to use a street address for delivery when filling out the publications order form. Materials also can be downloaded

directly from the Web site and saved to a local computer.

Visit the Oklahoma Health Care Authority at www.okhca.org.

Download publications from www.okhca.org/publications/publications.asp.

Oklahoma Bureau of Narcotics Launches Program to Halt 'Doctor Shopping'

Effective July 1, 2006, the Oklahoma Bureau of Narcotics and Dangerous Drugs Control (OBNDCC) launched a new program, CONTROL (Comprehensive Oklahoma Narcotics Tracking and Regulation On Line), to identify people involved in scamming multiple doctors and pharmacies to illegally acquire prescription drugs, commit prescription fraud and abuse prescription drugs.

OBNDCC spokesman Mark Woodward reported that the new program is an extension of the OSTAR program that began in 1990

and addressed Oklahoma Schedule II Abuse Reduction.

The CONTROL program, also known as the Prescription Monitoring Program (PMP), has been expanded to electronically track not only Schedule II controlled substances, but also Schedule III, IV and V prescriptions. Access to the new PMP application will be granted to state regulatory, licensing and law enforcement agencies in accordance with 63 O.S. § 2-309D. Privacy issues have been addressed and safeguarded for individuals who will be identified in this program.

(Continued on Page 6)

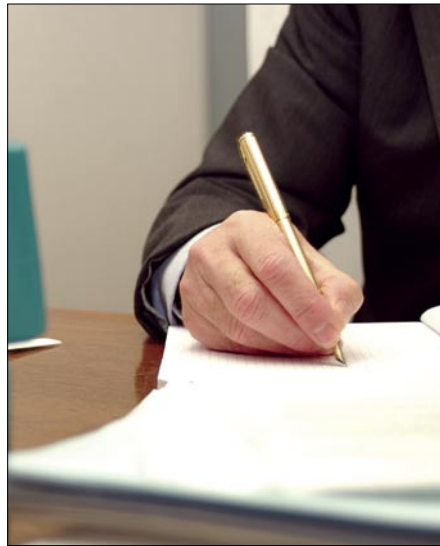


Marathon Legislative Session Produces Funding, Reform

Dust continues to settle as the Oklahoma Health Care Authority reviews the impact of the last meeting of the 50th Legislature. Thousands of ideas resulted in nearly 400 bills signed by Gov. Brad Henry. Four of those bills will have a profound impact on the future activities of this agency and the more than 700,000 people we expect to serve this year.

House Bill 1071XX – This is the agency's appropriation bill that was approved in June's special session. For state fiscal year 2007, the agency's budget will reach a record \$702 million in state funds.

This appropriation funds our projected enrollment growth and utilization increases of 5 percent, or \$40 million. In addition to annualization and maintenance needs, this budget provides \$622,806 for enhanced services to high risk OB patients; \$13,171,229 to increase hospital provider rates to the upper payment limit beginning Jan. 1, 2007; and \$5,269,296 for the provisions of the Medicaid Reform Act of 2006 (HB 2842), including authorization for 31 new full-time employees. This



bill also provides \$22,594,707 to increase rates for nursing home and ICF/MR providers effective July 1, 2006. Regular nursing facility rates will range from \$113 to \$119 per patient day based on the facility's ratio of direct care staff.

Efficiencies by the agency also allowed the legislature to use almost \$50 million in state dollar savings toward this year's appropriation. This includes a \$12.5 million reduction in the agency's budget due to ongoing savings and \$35 million in carryover savings earned by agency

efforts during the past few years including increased drug rebates and money saved after dissolution of the **SoonerCare** Plus program.

House Bill 2842 – This bill may have the greatest impact on Medicaid policy since the legislature expanded the program to cover more children in 1997. The bill endorses many policy changes found in the agency's strategic plan including e-prescribing, disease management, payment error rate reductions, emergency room utilization management, alternatives to long-term care and long-term care reimbursement changes. In addition, this bill has two primary waivers requiring policy development. The waivers focus on patient empowerment initiatives and expanding coverage to college students. The bill also expands the premium assistance program to allow employers of 50 employees or less to participate and potentially expands coverage to parents of children on **SoonerCare**.

(Continued on Page 11)

Oklahoma Bureau of Narcotics Program to Halt 'Doctor Shopping' (continued from page 5)

The CONTROL/PMP program was created using federal grants specifically set aside for prescription monitoring programs in the United States. The Oklahoma program has secured funding for two data entry personnel and three years of program operation.

Beginning July 1, 2006, all submissions began being sent directly to OBNDCC instead of a

third-party data collection service. Beginning Aug. 1, 2006, it became mandatory to report to OBNDCC all dispensing records for controlled substances using the ASAP r. 5/95 format within 30 days of the time the controlled substance was dispensed.

For more information and updates about CONTROL/PMP, please visit the following Web site:
www.obn.state.ok.us/PMP.htm.

August 2006 Brought Added Safety Features to ePocrates®

Drug safety information has been expanded to assist customers in prescribing and monitoring medications more effectively in the following areas:

- Black box warnings
- Monitoring parameters
- Therapeutic and toxic drug levels
- Non-interchangeable forms

For more information on these recent changes, please visit:

www.okhca.org/provider/types/pharmacy/epocrates.asp
or
www.epocrates.com



Claims/Systems News

oklahoma health care authority

Providers Offered Ways to Avoid Mass Adjustments

A recent provider survey conducted by EDS and OHCA revealed a desire among many providers to understand the mass adjustment process. Mass adjustments are performed by OHCA when a large volume of claims are found to have been processed incorrectly.

There are several reasons why a large number of claims would have the same adjustment code, ranging from a system programming error to inaccurate rates on file that determine the reimbursement for a certain procedure and result in either an overpayment or underpayment to the provider. If OHCA receives notification of changes in federal rates after final implementation, all claims paid at the old rate are to be recycled to pay at the newer rate.

Errors are often discovered by providers and reported to OHCA when payments for procedures have been

(Continued on Page 8)



Did You Know?

Oklahoma Health Care Authority pays 100 percent of the coinsurance/deductible assigned by Medicare, effective for services provided on or after Aug. 1, 2005.

Oklahoma Health Care Authority follows the state fiscal year when updating the RVU file. Medicare 2006 RVUs became effective July 1, 2006.

All claims submitted to **SoonerCare** by noon on Wednesday of each week will be processed and included in the following week's financial cycle.

Third Party Liability (TPL) non-Medicare claims may be billed on the secure Web site using Direct Data Entry (DDE) as follows:

- Check eligibility on the Web; if the member's eligibility indicates they have private insurance (TPL), the provider/billing agency must submit the claim to the TPL first.
- Submit the claim (after adjudication) on the secure Web site.
- If the TPL makes some form of payment, enter the amount paid in the TPL box:
 - For professional claims: in the second box, third column.
 - For institutional claims: in the second box, third column, sixth row.
 - For dental claims: in the second column, sixth row.
- When submitting a claim with TPL payment, OHCA does not require an EOB with the claim for processing.
- If submitting a TPL claim and the TPL has either been denied or has applied the amount to the deductible, an EOB should be sent in order for the claim to process. This method requires the HCA-13 cover sheet and additional training for the claim to process correctly. Anyone interested in learning this process should contact their EDS field consultant to schedule training.

The patient may be billed for any **SoonerCare** claim that was denied as a noncovered charge. If you billed **SoonerCare** \$75 for an office visit and the allowable amount is \$48, you must write off the difference. However, if the procedure code billed is a non-covered charge or the patient is not eligible on the date of service, the patient can be billed for the non-covered charges.

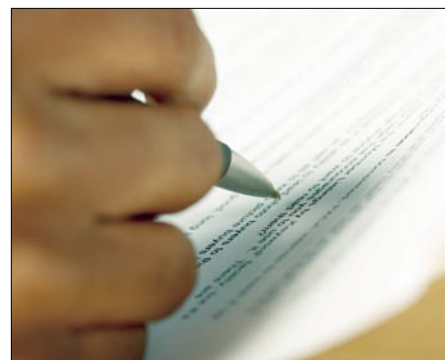
(Continued on Page 8)

Providers Offered Ways to Avoid Mass Adjustments (continued from page 7)

incorrect. When an error has affected numerous claims from several different providers, the necessary changes can be made to the system affected, and those claims are recycled for correction.

Along with our global messages, banner pages and other means of notification, mass adjusted claims appear on the “Adjustments” section of the remittance advice (RA). Errors are identified by an individual claim number (ICN) that begins with the digits “52.”

If you have questions about a mass adjustment that has affected you directly, please call the Adjustments Unit, Option 6 on the Provider Helpline at 1-800-522-0114.



Did You Know? (continued from page 7)

Training is available to all health care providers and billing staffs **FREE OF CHARGE**.

Regardless of whether the training consists of the spring/fall workshops, on-site training at the provider's location or the bimonthly Medicaid 101 classes held in Oklahoma City and Tulsa, the trainings are offered at no cost to the provider. Trainings for one or 100 are free and may be arranged by contacting either your EDS field consultant or OHCA provider services representative.

The secure Web site may be used to work any of your denied claims, whether they were originally submitted via direct data entry on the Web, electronically or on paper. Currently, the Medicare crossover claims are the only claims that cannot be corrected on the Web site.

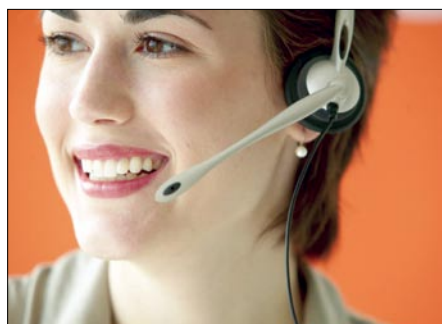
Providers are allowed to collect co-pays from **SoonerCare** members at the time of service, if applicable. Co-pays are not required of some populations, such as children, pregnant women, nursing home clients and members on some waiver programs. If the member is unable to pay the co-pay at the time of service, the provider cannot deny care/services because of the

member's inability to pay, but may choose to bill at a later date. The member is still responsible for the co-pay. Once the provider receives the Remittance Advice (RA) for the member's service(s), please review billing records to determine if the co-payment was collected or needs to be billed.

We Appreciate Your Comments

1. Provider comment: OHCA purposely overpays claims to get a federal match, then recoups the money from providers and keeps the difference.

OHCA response: [42 CFR Part 433.312] The state must refund the federal share of all overpaid claims to CMS within 60 days of discovery of an overpayment, “whether or not the state has recovered the overpayment from the provider.”



2. Provider comment: Hospital claims are held in a special holding area and paid last in the financial cycle. If funds run short, hospitals are not paid until the next cycle.

OHCA response: All claims are processed and paid in the order they are received, regardless of dollar amount, provider type, etc.

3. Provider comment: OHCA auditors get a commission on every dollar of overpayment they discover.

OHCA response: State-employed auditors are paid a monthly salary, not a percentage of recoupment. State-contracted auditors are paid flat rate, not a percentage of recoupment.

4. Provider comment: It is difficult to obtain training when we have questions or issues.

OHCA response: All providers have an EDS field consultant and an OHCA provider services representative assigned to help with any **SoonerCare** program question. These two individuals can assist you with questions related to billing, claims submission, referrals, contract or policy interpretation and any other issue that may arise, in order to

(Continued on Page 9)

PERM Requirements May Prompt Records Requests

On Oct. 1, 2005, the federally mandated Payment Error Rate Measurement (PERM) program became effective. PERM is a federal program designed to measure the accuracy with which states pay Medicaid and State Children's Health Insurance Program (SCHIP) claims for medical services rendered to members.

Some **SoonerCare** providers may be asked to supply medical records to

comply with PERM.

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees PERM. CMS developed PERM to meet the requirements of the Improper Payments Information Act of 2002. That act directs federal agencies, in accordance with Office of Management and Budget (OMB) guidance, to annually review its programs that are susceptible to

significant erroneous payments and report the improper payments to Congress. OMB identified the Medicaid and SCHIP programs as being at risk for significant erroneous payments.

CMS will use national contractors to complete PERM. The Lewin Group will randomly select the claims to be reviewed and calculate the state's accuracy rate. Livanta LLC

(Continued on Page 10)

(Continued from Page 8)

assist in providing quality care to our **SoonerCare** members. Information may be accessed by telephone, individual onsite visits and in the biannual spring and fall trainings. To learn who your field consultant and/or **SoonerCare** Choice representative is, call 1-800-522-0114, option 1. Ask the call center for the names of the representatives in your county. All training is available at no charge; contact your representative to schedule a training visit.

5. Provider comment: Third Party Liability (TPL) or private insurance claims cannot be filed on the secure Web site (Medicaid on the Web).

OHCA response: All non-Medicare TPL claims can be filed on the secure Web site. Please contact your EDS field consultant or the Internet Help Desk for assistance.

6. Provider comment: OHCA pays the provider claims.

OCHA response: The Oklahoma Health Care Authority has a contract with Electronic Data Systems (EDS), which processes all claims. The information is approved by OHCA and is then sent to the State Treasury office for distribution.

New Periodicity Schedule for Child Health/EPSTD Screen Began July 1st

Changes to the recommended visits are as follows:

- A newborn visit was added (to be performed in the hospital).
- A one-week visit was added (optional for babies released early from the hospital or who are at risk for other medical problems).
- The 15-month visit was made optional.
- All of the visits after age 6 are to be performed during the even years (i.e., ages 8, 10, 12, etc.). Visits during the odd-numbered years are optional.

The new periodicity schedule was implemented in late summer, with notification of providers by mail. OHCA has designed educational and training materials to assist providers in effectively transitioning to the new schedule and screening recommendations.

Please feel free to contact any of the following staff if you have questions or require assistance in matters pertaining to children's health:



- Ivoria Holt, manager of child health
(405) 522-7352
ivoria.holt@okhca.org
- Sue Robertson, child health specialist
(405) 522-7269
sue.robertson@okhca.org
- LaQueda McDonald, child health specialist
(405) 522-7504
laqueda.mcdonald@okhca.org

For current information about EPSTD services and future developments regarding the periodicity schedule, please check www.okhca.org.

PERM (continued from page 9)

will provide documentation/database support by collecting state medical policies and medical records from providers. Health Data Insights will perform the medical and processing validation reviews. Again, medical records will be necessary to support services rendered. Providers that have a claim selected for review will be contacted by Livanta LLC for a copy of their medical records.

Understandably, providers will be concerned about maintaining the privacy of patient information. However, providers are required by § 1902(a)(27) of the Social Security Act to retain records necessary to disclose the extent of services provided to individuals receiving assistance and furnish CMS with information regarding any payments claimed by the provider for rendering services; this includes medical

records. In addition, the collection and review of protected health information contained in individual-level medical records for payment review purposes is permissible by the Health Insurance Portability and Accountability Act of 1996 and implementing regulations at 45 Code of Federal Regulations, parts 160 and 164.

Generally, to obtain medical records for a claim sampled for review, Livanta LLC will contact the provider to verify the correct name and address information and to determine how the provider prefers to receive the request(s) (facsimile or U.S. mail) for medical records. Once the provider receives the request for medical records, the provider will have 90 days to submit the information electronically or in hard copy. Livanta LLC, and

state officials, may follow up to ensure that providers submit the documentation before the 90-day time frame has expired.

It is important for providers to send all requested documentation, as failing to respond or providing insufficient documentation will result in a payment error. Past studies have shown those are the most significant causes of errors in medical reviews, so please send timely and complete information. If you have questions regarding requests for medical records from Livanta LLC, call Robin Reed at (301) 957-2380.

CMS has established a Web site at www.cms-perm.org where you can get general information and find answers to frequently asked questions. You may also contact Kelly Shropshire or Justin Etchieson with OHCA at (405) 522-7131 or (405) 522-7494.

SoonerCare Provider Services Introduces New Provider Representatives

The **SoonerCare** Provider Services Unit of Oklahoma Health Care Authority is pleased to announce the addition of Melissa Clampitt and Susan Loris to their staff of provider representatives. Both Melissa and Susan bring a wealth of knowledge and expertise to the **SoonerCare** program.

Melissa was previously an analyst in the Medical Authorizations Unit and has several years of valuable experience in managed care programs. She will be assisting providers in Creek, Osage, Pawnee, Rogers and Washington counties. She will also share responsibilities with Shannon Tiller in Tulsa County and with Amanda Bell-Willett in Oklahoma County. She may be

contacted by phone at (405) 522-7567, by fax at (405) 530-3233 and by e-mail at melissa.clampitt@okhca.org.

Susan has returned to her role as an OHCA provider representative following an 18-month absence, during which time she was employed with Humana Health Systems in Houston, Texas. Susan will be assisting providers in Alfalfa, Beaver, Beckham, Blaine, Cimarron, Custer, Dewey, Ellis, Garfield, Grant, Harper, Kay, Kingfisher, Major, Noble, Roger Mills, Texas, Washita, Woods and Woodward counties, as well as in Seward and Sumner counties in Kansas. Susan may be contacted by phone at (405) 522-7509, by fax at (405) 530-3361 and by e-mail at susan.loris@okhca.org.

A complete listing of all provider representatives may be found on OHCA's Web site, www.okhca.org. They may also be reached by telephone toll free at 1-877-823-4529, option 2.

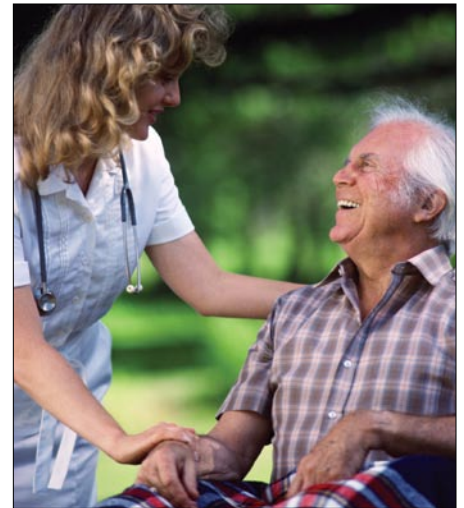


Marathon Legislative Session (continued from page 6)

House Bill 2102 – An agency request bill, this legislation altered the responsibilities of the person who represents the pharmaceutical manufacturers on the agency’s drug utilization review board (DUR). This member will no longer be able to vote on action items involving prescription drugs to avoid any potential conflict of interest. This change is effective Nov. 1, 2006.

Senate Bill 2017 (the “Opportunities for Independent Living Act”) – The legislature established a three-year pilot program to transition individuals out of institutional care into a community care setting. In coordination with the Department

of Human Services Aging Division, this pilot will identify 30 people who have requested to receive their services in a community setting. Subject to the availability of funding, the agency will assist qualified individuals with disabilities who live in institutions to transition into the community. OHCA will contract with consumer-controlled, non-residence-based, community-based, nonprofit organizations with experience in transitioning people with disabilities into community settings. The pilot program will use available funding to assist eligible people in paying rent and utility deposits; purchasing initial household supplies, basic initial



household appliances and initial furniture; and paying moving expenses. The transition is estimated to cost \$2,500 per person.

Antibiotic Resistance, Utilization Explored

By Christendoza Le, Pharm.D.

With the upcoming cold and influenza season, the issue of antibiotic resistance and appropriate antibiotic dispensing are once again a topic of conversation. The emergence of antibiotic resistance is a well-documented fact and is always a concern to health care providers, but balancing the need for patient care and satisfaction with the need for appropriate prescribing can be a difficult task. OHCA would like to assist our prescribers in managing this sensitive area this season.

Several major factors contributing to the emergence of antibiotic resistance are:

1 Natural survival mechanisms of microbes

- Fast replication and ability to adapt to new environmental conditions allow for the survival of resistant organisms.
- The resistant trait is passed on to offspring and other related bacteria and eventually resistance dominates throughout the microbial population.

2 Inappropriate use and misinformation

- The CDC estimates that among office-based physicians, more than 50 percent of prescriptions for antibiotics are unnecessarily prescribed.
- Patients contribute to resistance by pressuring doctors to prescribe antibiotics when it is not necessary, failing to follow dosing schedules and not finishing the course of the prescribed antibiotic.

- Hospitals contribute to resistance by noncompliance of infection control practices and extensive use of antibiotics.
- The use of antibiotics as growth promoters in the livestock industry is still debatable; however, this practice will certainly contribute to antibiotic resistance.

3 Aging of the population

- The elderly are living longer and are at increased risk of infections compared to the younger population.
- Infections are more difficult to treat in the geriatric population, and as a result, elderly patients are more likely to be hospitalized and die of infections.

(Continued on Page 12)

Antibiotic Resistance, Utilization Explored (continued from page 11)

Emerging Trends in Antibiotic Resistance

For an overall picture of resistance trends among some commonly used antibiotics, the Oklahoma Department of Health has collected and reported the following data on Figure 1.

Nationally reported resistance rates for Azithromycin are similar to Erythromycin at 20 percent to as high as 50 percent. Fluoroquinolone resistance rates are reported to be minimal at around 1 percent to 3 percent for *Streptococcus pneumoniae*.

Utilization of Select Antibiotic Classes

The following data are gathered from the paid pharmacy claims for the non-Medicare eligible population utilizing one of the selected antibiotic classes during the calendar year 2005:

- Ampicillins
- Penicillin combination products
- Azithromycin
- Third-generation cephalosporins
- Fluoroquinolones

When the databases of the selected antibiotic classes were combined, a total of 428,104 claims were incurred by 217,606 non-Medicare eligible members. The claims were analyzed to compile the following charts that show utilization in various parts of Oklahoma (see Figures 2 and 3).

The following are the most common day's supply that were entered on claims. Approximately 95 percent of the claims were filled for the following day's supply as seen on Figure 4.

(Continued on Page 13)

Figure 1 Nonsusceptibility Rates of *Streptococcus pneumoniae**

Hospital Location	Isolates	Antibiotic		
		Penicillin	Erythromycin	3rd Gen Ceph
OKC Metro Area	1,091	12%	28%	5%
Tulsa Metro Area	367	10%	18%	3%
Oklahoma - Others	616	11%	30%	1%
Oklahoma - All	2,074	12%	27%	3%

**Streptococcus pneumoniae* was reported as the leading cause of organism-specific related death in Oklahoma.²

Figure 2 Regions Ranked by Percent of Claims

Ampicillins		Pen Combinations		Azithromycin		3rd Gen Ceph		Fluoroquinolones	
Region	Percent	Region	Percent	Region	Percent	Region	Percent	Region	Percent
OKC	31.2	OKC	31.5	OKC	22.3	OKC	32.7	OKC	27.2
Tulsa	17.3	SE	17.6	SE	22.0	SE	18.7	SE	21.1
SE	17.2	Tulsa	15.3	NE	16.4	NE	15.3	NE	17.0
NE	15.0	NE	12.7	Tulsa	15.1	Tulsa	15.0	Tulsa	15.8
SW	10.7	SW	11.8	SW	14.1	SW	9.3	SW	12.2
NW	8.5	NW	11.1	NW	10.2	NW	9.0	NW	6.8

Figure 3 Top 10 Counties Ranked by Percent of Claims

Ampicillins		Pen Combinations		Azithromycin		3rd Gen Ceph		Fluoroquinolones	
County	%	County	%	County	%	County	%	County	%
Oklahoma	19.9	Oklahoma	16.4	Oklahoma	12.5	Oklahoma	19.5	Oklahoma	17.6
Tulsa	11.0	Tulsa	9.3	Tulsa	9.0	Tulsa	9.2	Tulsa	10.4
Cleveland	4.9	Cleveland	5.6	Cleveland	4.2	Cleveland	4.7	Cleveland	4.3
Muskogee	2.6	Pottawat.	4.0	Comanche	2.9	Pottawat.	4.1	Muskogee	3.1
Pottawat.	2.3	Kay	3.0	Le Flore	2.9	Muskogee	3.8	McCurtain	2.8
Le Flore	2.2	Canadian	2.9	McCurtain	2.4	Pittsburg	3.5	Comanche	2.8
Comanche	2.0	Comanche	2.6	Muskogee	2.2	McCurtain	3.0	Sequoyah	2.3
Creek	2.0	Payne	2.4	Garfield	2.1	Payne	2.3	Ottawa	2.2
McCurtain	1.9	Creek	2.3	Carter	2.1	Comanche	2.2	Le Flore	2.1
Canadian	1.9	Carter	2.2	Mayes	2.1	Canadian	2.1	Pottawat.	2.0
TOTAL	50.6	TOTAL	50.7	TOTAL	42.4	TOTAL	54.4	TOTAL	49.6

Antibiotic Resistance, Utilization Explored (continued from page 12)

The generic utilization of each class is listed on the following table. Remember that the mandatory generic plan applies, and a brand name override petition must be submitted for consideration where there is a generic available.

- Y = indicates generic product utilized.
 - N = indicates no generic product available.
 - O = indicates generic product available, but brand name product was utilized.
- (See Figure 5)

Inappropriate utilization of antibiotics results in two major sequelae: rapid propagation of antibiotic resistance and increased health care costs. With antibiotic resistance, each infection is more difficult to treat, resulting in increased resource utilization, morbidity and mortality.

Of the factors contributing to the emergence of antibiotic resistance mentioned, one factor that can be altered is the inappropriate use and misinformation regarding antibiotics. In the coming months, the Oklahoma Health Care Authority will be making mass mailings to select members and their families as well as to prescribers. The materials will include patient-targeted educational materials about the inappropriate use of antibiotics. Please be prepared to answer any questions your patients may have about when antibiotics will work and when they won't work, such as for cold or flu.

Figure 4 Top 10 Day's Supplies Ranked by Percent of Claims

Ampicillins		Pen Combinations		Azithromycin		3rd Gen Ceph		Fluoroquinolones	
Days	% of Claims	Days	% of Claims	Days	% of Claims	Days	% of Claims	Days	% of Claims
10	75.2	10	73.0	5	72.4	10	62.0	10	33.6
7	11.6	7	10.0	3	12.5	7	7.9	7	27.9
5	2.5	12	4.5	6	4.8	12	7.8	5	12.7
6	1.7	14	2.4	4	3.3	5	5.5	14	5.7
13	1.3	15	2.0	1	3.0	6	3.0	3	5.5
14	1.1	5	1.9	10	0.9	13	1.8	30	3.3
1	1.1	13	1.4	7	0.9	13	1.8	30	2.4
8	0.9	8	0.8	2	0.7	8	1.7	15	1.4
15	0.7	20	0.7	30	0.5	14	1.5	6	1.4
12	0.7	6	0.6	8	0.3	20	1.3	4	1.1
TOTAL	96.7	TOTAL	97.3	TOTAL	99.2	TOTAL	94.8	TOTAL	94.9

Figure 5 Percent Generic Utilization Among Select Antibiotic Classes

Generic	Ampicillins	Pen Combos	Azithromycin	3rd Gen Ceph	Fluoroquinolones
Y	98.6%	85.3%	4.1%	1.9%	44.2%
N	0.5%	13.7%	91.7%	96.6%	55.4%
O	0.9%	1.0%	4.2%	1.5%	0.0%

Other Resources for Providers

Patient-targeted educational materials are also available from the CDC for printing or viewing at the following Web site: www.cdc.gov/drugresistance/community/campaign_materials.htm. Some helpful materials available on this Web site include:

- Educational materials on colds and flus.
- Runny nose Q & A.
- Fluid in the middle ear Q & A.
- Daycare letter.
- Prescription pad.
- Prescription adherence reminder.
- Virus vs. Bacteria infection chart.
- Other helpful materials for physicians are also available from the CDC including practice guidelines for treatment of

infections. They can be found at www.cdc.gov/drugresistance/community/healthcare_provider.htm.

Our common goal is to reduce the emergence of antibiotic resistance in Oklahoma. With the assistance of our providers and available educational resources, OHCA hopes to make this goal a reality and continue to improve the health of our patients and members.

Resources

1. Roth CS, Corcoran DJ. Emerging Trends in Antibiotic Resistance: Strategies for Appropriate Antibiotic Use. Managed HealthCare Executive. December 2005. Vol 15. Supplement 1.
2. Oklahoma Dept. of Health. 2004 Annual Summary of Infectious Diseases. Available online at: www.health.state.ok.us/program/cdd/2004%20Annual%20Summary.pdf

Generic Use, Adherence Effective for Patients

By Metha Chonlahon, Pharm.D.

The Hatch-Waxman Act passed by Congress in 1983 established a process to provide patients with access to affordable alternatives to expensive branded medications that are safe and effective. Patients who take generic medications can achieve optimal or improved therapeutic outcomes while alleviating the burden of costs often associated with branded medications.

Facts and Figures ^{1,2,3,4,5,6,7,8}

1. Health care costs are expected to increase to \$3.4 trillion by 2013.
2. About 15 percent of health care costs are for prescription benefits.
3. \$100 billion in health care costs are due to lack of adherence to therapy.
4. About 50 percent of people with chronic disease comply with therapy.
5. Approximately 65 percent of Americans are enrolled in a three-tier pharmacy benefit program.
6. Generic products result in about 60 percent cost savings versus branded products.
7. About 17 percent of physicians are fully aware of actual FDA standards of bioequivalency.
8. FDA recognizes a generic drug as bioequivalent if made up of the same active ingredients as a branded drug and the rate and extent of absorption falls between -3 percent to 4 percent or less compared with branded drug.



Adherence Poses Major Challenge

A major challenge of pharmacotherapy with both acute and chronic diseases is proper management and adherence to a prescribed medication regimen by the patient. Both the initial drug selection process and the level of patient adherence to therapy can have a profound effect on costs and, more important, achieve optimal therapeutic outcomes.

Adherence can be influenced by many factors involving issues of personal beliefs, values, culture, mental capacity, understanding of disease, and surrounding support system among patients and prescribers. Adverse effects, complexity of dosing regimen, and financial considerations also influence prescribing and patient adherence to therapy.

The prescriber's knowledge of evidence-based treatment guidelines, pharmacy formulary design and the availability of generic alternatives to expensive branded products can assist in the drug selection process resulting in optimal cost-effective health care.

Difference in Adherence ^{4,5}

An article published in the Feb. 13, 2006, issue of Archives of Internal

Medicine shows that patients who take generic medications for treatment of chronic diseases are more likely to adhere to prescribed therapy than those who take branded medications.

The study analyzed pharmacy claims data from a database of 6,755 patients enrolled in a three-tier pharmacy benefit structure. The benefit plan required higher copays for non-preferred branded drugs (third tier), smaller copays for preferred branded drugs (second tier) and smallest or no copay for generic drugs (first tier). Compared with non-preferred branded drugs, patients were shown to have a 12.6 percent increase in adherence with generic drugs and 8 percent increase in adherence with preferred second-tier drugs. In other findings, patients had a 62 percent chance of achieving adherence with generic drugs compared with brand name drugs and 30 percent better odds with second-tier drugs. Patients who initially filled third-tier drugs were 2.1 times more likely to switch to a lower-tier drug. Patients were also 2.8 times more likely to switch to a less expensive lower-tier drug than to a higher-tier drug. Patients who initially filled generics switched at less than half the rate compared with those who filled with third-tier drugs.

In a recent study published in *Annals of Pharmacotherapy*, 1,028 patients were assessed for adherence to antihypertensive therapy after switching from branded drugs to less costly generic drugs. The impact of generic drug use and the effect on adherence was measured by

(Continued on Page 15)

Generic Use, Adherence Effective for Patients (continued from page 14)

reviewing drug dispensing records and hospital discharge notes. The findings reported that 13.6 percent of patients who switched to generic drugs were nonadherent to therapy. In contrast, 18.7 percent of patients who remained on branded drugs were nonadherent. No differences were found in hospitalization due to cardiovascular events during a six-month period after switching from branded drugs to less costly generic drugs.

Generic Drugs Proved Useful

These articles demonstrate the impact of initial drug selection on patient adherence to therapy and the overall cost of care. Using generic drugs according to evidenced-based treatment guidelines can achieve

improved therapeutic outcomes without adversely affecting disease progression. As generic products become available, they should be used unless there are substantial clinical reasons why branded drugs would be more appropriate. Pharmacists can assist in the drug selection process by providing vital information regarding generic drug availability and recent evidence-based treatment guidelines to ensure quality of care while minimizing overall health care costs.

References:

1. Christian-Herman J, Emons M, George D. Effects of Generic-Only Drug Coverage in A Medicare HMO. Health Affairs Sep 2004. Available at: www.healthaffairs.org. Accessed April 20, 2006.
2. Dezii CM. Medication Noncompliance: What is the problem? Managed Care

Special Supplement 2000: 7-12.

3. Bloom BS. Daily regimen and compliance with treatment. *Brit Med Jnl* 2001;323:647.
4. Shrank WH, Hoang T, Ettner SL, Glassman PA, Nair K, DeLapp D, Dirstine J, Avorn J, Asch SM. The Implications of Choice. *Arch Int Med* 2006;166:332-337.
5. Van Wijk BL, Klungel OH, Heerdink ER, Boer A. Generic Substitution of Antihypertensive Drugs: Does it Affect Adherence? *Annal of Pharm* 2005; 40:15-20.
6. Kaiser Daily Health Policy Report. Medical News Today: Increase Use of Generic Medications Could have saved \$20 Billion This Year, Report Finds. Available at www.medicalnewstoday.com/medicalnews.php?newsid=32628.
7. Banahan BF, Kolassa EM. A Physician Survey on Generic Drugs and Substitution of Critical Dose Medications. *Arch Int Med* 1997;157:2080-2088.
8. Barr Pharmaceuticals, Inc. Health Policy Issue Brief. Generic Pharmaceuticals Are the Same as Their Brand Counterparts. Available at: www.barrlabs.com. Accessed April 20, 2006.

Fall Training Dates Set for Medical and Non-Medical Providers

Fall 2006 Provider Training will take a slightly different focus this year. Sessions will be directed toward the medical and non-medical health care providers. The two groups will have separate training sessions in order to provide information specific to each group, even though the topics for both groups will be the same.

Non-medical providers training will include the following categories: personal care, room and board, respite care, direct support services, specialized foster care, adult day care, employee training specialists, homemaker services, architectural modification, residential behavioral management, Advantage home delivered meals, DDS-Non-Fed-

Med, direct supportive living and group homes.

Training topics will include:

Medical Providers

- National Provider Identifier (NPI)
- Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC)
- 1500 Claim Form

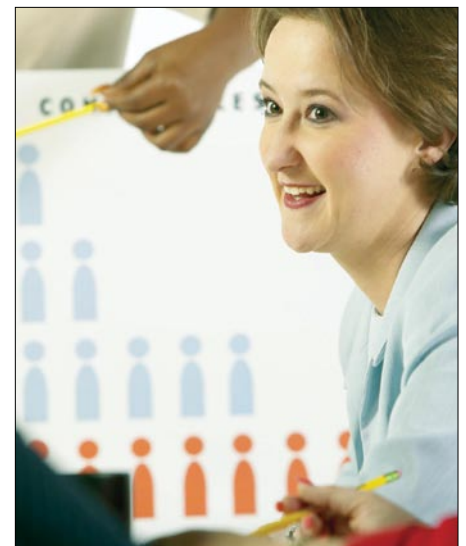
Non-Medical Providers

- New Provider Numbers
- O-EPIC
- 1500 Claim Form

Training dates and locations:

- 09/19/2006 - Oklahoma City
- 09/20/2006 - Oklahoma City
- 09/26/2006 - Durant

If you did not receive a registration form, you may call (405) 522-6205 in the Oklahoma City area or (800) 522-0114, option 1.



Provider Update is published by the Oklahoma Health Care Authority for Oklahoma's medical providers.

This publication is issued by the Oklahoma Health Care Authority in conjunction with APS Healthcare, Inc., as authorized by 63 O.S. Supp. 1997, Section 5013. Twenty-one thousand fifty pieces have been printed at a cost of .54 cents per copy. Copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries.

The Oklahoma Health Care Authority does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment or the provision of services.

Please submit any questions or comments to Meri McManus in the Oklahoma Health Care Authority's Public Information Office at (405) 522-7026.

Oklahoma Health Care Authority

4545 N. Lincoln Blvd., Ste. 124,
Oklahoma City, OK 73105-9901

Chief Executive Officer

Mike Fogarty

Medicaid Director

Lynn Mitchell, MD, MPH

Managing Editor

Meri McManus
Public Information Representative

Editor

Katherine Dalle
Director, Provider Services

Designer

S Design, Inc.

OHCA Board of Directors

Lyle Roggow
Chairman, Enid
Ed McFall
Vice Chairman, Lawton/Frederick
George A. Miller, *Bethany*
Anne Roberts, *Oklahoma City*
Wayne Hoffman, *Poteau*
Sandra Langenkamp, *Tulsa*
Bill Anoatubby, *Ada*



PRESORTED
STANDARD
US POSTAGE
PAID
PERMIT NO. 926
OKLA. CITY, OK

Oklahoma Health Care Authority
4545 North Lincoln Boulevard, Suite 124
Oklahoma City, Oklahoma 73105-9901