

Winter 2006  
**Provider Update**  
 A publication of the Oklahoma Health Care Authority

## Hospital reimbursement methodologies revised Oct. 1

Changes to hospital reimbursement methodologies that went into effect Oct. 1, 2005, are expected to positively affect health care in Oklahoma, according to the Oklahoma Health Care Authority (OHCA).

Payment for inpatient stays in acute care (excluding Indian Health hospitals) and critical access hospitals are now determined using a Diagnosis Related Group (DRG) methodology. With the new payment method, the 24-day limit for adults has been eliminated. DRG methodology will be applicable to all Medicaid client eligibility programs. Hospitals not affected by DRGs will continue to be paid on a per diem rate.

The prospective payment rate will include all items and non-physician services furnished directly or indirectly to inpatients, including but not limited to:

- Laboratory services.
- Pacemakers and other prosthetic devices, including lenses and artificial limbs, knees and hips.
- Radiology services, including computed tomography (CT) or magnetic resonance imaging (MRI) scans furnished to a patient by a physician's office, other hospital or radiology clinic.
- Transportation (including by ambulance) to and from another hospital or free-standing facility to receive specialized diagnostic or therapeutic service.

Each affected facility should have received an individual letter from OHCA containing its peer group and base rate. If you are not sure of the provider specialty of your facility,

call (800) 522-0114, option 5, or (405) 522-6205, option 5. If you have questions about the base rate or peer group of your facility, call (405) 522-7083.

More information on inpatient hospital payments, including the DRG weights, is available on the OHCA Web site at <http://www.okhca.org/provider/types/hospitals>.



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# Prior authorization changes

## Effective Oct. 1, 2005:

- Atacand, Atacand HCT, Concerta\*, Focalin\*, Focalin XR\*, Wellbutrin XL and all ARBs have been reclassified as Tier-1 medications and will no longer require prior authorization. \*All stimulant / ADHD medications will continue to require authorization for clients 21 years of age or older.
- Advicor, Pravachol, Celexa and Lexxel have been reclassified as Tier-2 and will now require prior authorization.
- Prior authorization is required for statins, bladder control agents and dual acting antidepressants, now classified as Tier-2 medications. Tier 1 medications will continue to be covered with no prior authorization requirement.
- In order to prevent disruption of therapy for individuals who are currently using Tier-2 medications, any client whose Medicaid claims history reflects prior stabilization with a Tier-2 medication will be allowed to continue therapy without interruption.

## STATINS (HMG-CoA Reductase Inhibitors)

- Tier-1 products are covered with no authorization necessary.

### Tier-2 authorization requires:

- Documented trial of a Tier-1 medication with inadequate results after a minimum of 6-8 weeks of continuous therapy at standard to high dose, or
- Documented adverse effect or contraindication to the Tier-1 products, or
- Documented increased risk for drug interactions.

<b>Tier-1 (no PA required)</b>	<b>Tier-2 (requires PA)</b>
fluvastatin (Lescol, Lescol XL)	pravastatin (Pravachol, Pravigard)
lovastatin (generic & Altoprev)	lovastatin (Mevacor)
atorvastatin (Lipitor)	lovastatin / niacin (Advicor)
rosuvastatin (Crestor)	
simvastatin (Zocor)	

## Dual Acting Antidepressants

- Tier-1 products are covered with no authorization necessary.

### Tier-2 authorization requires:

- Documented trial of a Tier-1 medication with inadequate results after a minimum of 4 weeks of continuous therapy, or
- Documented adverse effect, drug interaction, or contraindication to the Tier-1 products, or
- Documented FDA-approved indication for which Tier-1 products are not indicated.
- Petitions for coverage of a Tier-2 medication may also be submitted for consideration when a unique client-specific situation exists.

<b>Tier-1 (no PA required)</b>	<b>Tier-2 (requires PA)</b>
mirtazapine (Remeron, Remeron Soltab)	duloxetine (Cymbalta)
trazodone (Desyrel)	nefazodone (Serzone)
bupropion (Wellbutrin, Wellbutrin SR, Wellbutrin XL)	
venlafaxine (Effexor, Effexor XR)	

*continued on page 3*

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### SSRIs (Selective Serotonin Reuptake Inhibitors)

- Tier-1 products are covered with no authorization necessary.

#### Tier-2 authorization requires:

- Documented trial of a Tier-1 medication with inadequate results after a minimum of 4 weeks of continuous therapy, or
- Documented adverse effect, drug interaction, or contraindication to the Tier-1 products, or
- Documented FDA-approved indication for which Tier-1 products are not indicated
- Petitions for coverage of a Tier-2 medication may also be submitted for consideration when a unique client-specific situation exists.

<b>Tier-1 (no PA required)</b>	<b>Tier-2 (requires PA)</b>
citalopram (generic only)	citalopram (Celexa tabs and liquid)
escitalopram (Lexapro tabs and liquid)	fluoxetine (Sarafem)
fluoxetine (Prozac)	fluoxetine — tablets (all strengths)
fluvoxamine (Luvox)	and 40mg capsules
paroxetine (Paxil, Paxil CR, Pexeva)	
sertraline (Zoloft)	

### Bladder Control Medications

- Tier-1 products are covered with no authorization necessary.

#### Tier-2 authorization requires:

- Documented trial of a Tier-1 medication with inadequate results, or
- Documented adverse effect or contraindication to the Tier-1 products, or
- Documented FDA-approved indication for which Tier-1 products are not indicated.
- Hyoscyamine can be used as adjuvant therapy, but does not count as a tier-1 trial.

<b>Tier-1 (no PA required)</b>	<b>Tier-2 (requires PA)</b>
darifenacin (Enablex)	oxybutinin extended release (Ditropan XL)
flavoxate (Urispas)	
hyoscyamine (Levbid, Levsin, Cystospaz)	
oxybutynin (Ditropan, Oxytrol)	
solifenacin (VESIcare)	
tolterodine (Detrol)	
tolterodine extended release (Detrol LA)	
tropium (Sanctura)	

### ACE Inhibitor / Calcium Channel Blocker Combinations

- Tier-1 products are covered with no authorization necessary.

#### Tier-2 authorization requires:

- Documented trial of a Tier-1 medication with inadequate results, or
- Documented adverse effect or contraindication to the Tier-1 products, or
- Documented FDA-approved indication for which Tier-1 products are not indicated.

<b>Tier-1 (no PA required)</b>	<b>Tier-2 (requires PA)</b>
benazepril / amlodipine (Lotrel)	enalapril / felodipine (Lexxel)
trandolapril / verapamil (Tarka)	

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## Five main groups for new Medicare prescription drug coverage

Your patients will look to you for information about the new Medicare prescription drug coverage, so it is important to find out whether the person already has drug coverage under another plan. This will help them in the decision-making process. Below is a list of the five main groups and information that will help people in each group decide on the right Medicare prescription drug coverage plan for them.

### **No prescription drug coverage**

Medicare prescription drug coverage will help with drug costs. For a typical person with Medicare, this coverage, on average, will pay 50 percent of drug costs next year. You can join a Medicare Prescription Drug Plan that covers prescription drugs only and keep your other insurance, or you can join a Medicare Advantage Plan or other Medicare Health Plan that covers doctor and hospital care, as well as prescriptions. If you don't join a Medicare drug plan by May 15, 2006, you will have to pay a penalty if you decide to join later.

### **Employer/union coverage (including VA, TRICARE and Federal Employees)**

Your employer or union should contact you to let you know if your current coverage, on average, is at least as good as the standard Medicare prescription drug coverage. If you don't hear from them, visit their Web site or call your benefits administrator.

### **Medicare and Medicaid**

Starting Jan. 1, 2006, you will get your prescription drug coverage from Medicare instead of Medicaid. The prescription drug coverage from Medicare has no premiums, no deductibles and no gaps, and you will pay very little or nothing for almost all prescriptions. You must join a plan that covers prescription drugs to get drug coverage. If you don't join a plan, Medicare will sign you up for one to make sure you don't miss a day of coverage. You can change plans at any time.

### **Medicare Advantage Plan or other Medicare Health Plan**

Your plan will let you know about the prescription drug options they will offer. You can also choose to switch to another Medicare Advantage Plan, other Medicare Health Plan or the Original Medicare Plan and join a Medicare Prescription Drug Plan.

### **Medigap policy with prescription drug coverage**

Medicare prescription drug coverage will generally provide significant savings compared to what you are paying in co-payments for drugs under your Medigap plan, and it will generally provide much better protection

against high drug expenses. Also, Medicare coverage will never run out if you have high drug costs. If you decide to join a plan that offers Medicare prescription drug coverage, tell your Medigap insurer and the drug coverage portion of your Medigap policy will be removed. You won't be able to get it back. If you keep your Medigap policy with drug coverage and don't join a Medicare drug plan by May 15, 2006, in most cases, you will have to pay a penalty if you decide to join later.

### **Important for all audiences**

If someone has limited income and resources, he/she may qualify for extra help with Medicare Prescription Drug Plan costs. Visit [www.medicare.gov](http://www.medicare.gov) on the Web or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048.

### **Quantity limits and rounding up**

In order to avoid claims being rejected due to quantity limit restrictions, pharmacy providers should round up any day's supply figure that ends in a decimal.

For example, a client presents a prescription for 100 tablets at 3 x daily dosing.  $100 \text{ tablets} \div 3 = 33.33$  days' supply. In order to avoid the quantity limit rejection, the days supply on the claim should be rounded up to 34 days, not down to 33 days.



Oklahoma Health Care Authority



## OHCA MMIS NEWS

## Understanding SoonerCare referrals

**SoonerCare** Primary Care Providers (PCPs) may authorize, at their discretion, referrals to other contracted Medicaid providers for Medicaid compensable services that are outside their scope of practice or field of expertise. Referral requests for services that can be provided by the PCP will be denied. Referrals from the PCP require a medical determination and should be obtained prior to services being rendered. Referrals can be obtained after a service has been rendered if the PCP deems it appropriate.

Some services don't require a referral from the PCP. They include: child abuse exams, emergency room visits, obstetrical care, vision and dental screening under age 21, behavioral/mental health services, family planning services, diabetic supplies, most diagnostic lab and X-ray, inpatient hospital professional services, and services provided to American Indians at Indian Health Service, tribal or urban Indian clinics. All inpatient admissions, including admission from the Emergency Room, require a referral. Obstetrical admissions for the delivery of a baby are the only exception to this rule.

PCPs may issue referrals for one initial evaluation and treatment visit or for continuing care for up to 12 months. Referrals may be forwarded from one provider to another with the permission of the PCP for additional services related to the original diagnosis for which the patient was referred. The PCP does not have to issue a new referral for this.

Referral forms are completed by

the PCP's office and forwarded to the "referred to" provider. The form is called the SC-10 form and is available on the Oklahoma Health Care Authority (OHCA) Web site at [www.okhca.org](http://www.okhca.org). This form should include the patient's name and Medicaid ID number, the name and address of the referred to provider, the referring diagnosis, and a brief description of the services requested. This form requires the PCP's **SoonerCare** referral number in the appropriate box. PCPs with multiple service locations must use the location code where the patient is assigned.

Providers receiving a **SoonerCare** referral from a PCP will be reimbursed for their services based on the current Medicaid fee schedule. Referrals are not a guarantee of payment. Patients age 21 and older are limited to four specialty visits per month. Children under age 21 have unlimited specialty visits. When billing for services that require a referral, the **SoonerCare**

referral number is required in box 17a on the CMS 1500 form or line 82b on the UB92 form.

For more information concerning the **SoonerCare** referral process, please visit the OHCA Web site at [www.okhca.org](http://www.okhca.org). The Administrative Guidelines for Referrals are listed with the SC-10 form in the forms section of the Provider menu. You may also contact a **SoonerCare** Provider Representative at [877] 823-4529, option 2.



## Authorization process automated for MRIs

The Oklahoma Health Care Authority (OHCA) has implemented an automated payment process for certain Magnetic Resonance Imaging (MRI) procedures, effective for services rendered after Oct. 1, 2005. The OHCA anticipates this change will expedite payment and allow providers to identify those procedures predetermined to be compensable.

The OHCA has developed Medical Review Guidelines to identify conditions that will be automatically approved for various MRI procedures. These guidelines may be accessed on the OHCA Web site at [www.okhca.org](http://www.okhca.org) in the Provider section under "More Options," then the "What's New" section on the righthand side.

Claims being filed for payment of auto-approved conditions may be submitted through routine process and do not require additional documentation. However, documentation of medical necessity must be maintained in the recipient's medical record for all auto-approved

MRI procedures. If the condition indicated by the ordering physician is not included within the automatic approval guidelines, the procedure will require prior authorization.

To submit a request for an MRI procedure which requires prior authorization, the ordering provider should include all pertinent medical documentation with the HCA-12A

form and fax the documents to the Medical Authorization Unit at fax number (405) 530-3496.

For prior authorization questions, providers may contact the Medical Authorization Unit at the OHCA by calling 1-(800) 522-0114, option 9. For claims questions, providers should call the EDS Call Center at 1-(800) 522-0114, option 1.



## Training available on Web site

The Oklahoma Health Care Authority now offers training sessions to health care providers who can't attend regularly scheduled spring or fall sessions! Simply log on to [www.okhca.org](http://www.okhca.org), then select Providers, then Training.

Providers will find Web casts of sessions offered in spring 2005, along with printable slides from the presentations. For those with slower modem connections, there are slideshow presentations from both the spring and fall 2005 training sessions.

Information on the monthly Medicaid 101 classes in Oklahoma City and Tulsa is available. Information on future training sessions is posted as the locations and classes are confirmed.

For those who view or download the presentations, OHCA would appreciate feedback on the training through the "New Site Comments" tab. If providers find Web training useful, we will continue to add new sessions to the site.

## EPHI must be protected with encryption

The Oklahoma Health Care Authority (OHCA) implemented its encryption solution to secure Internet e-mails containing Electronic Protected Health Information on Nov. 1, 2005. If the receiver of an e-mail has an encrypted solution, no change is needed to receive the e-mail.

If the e-mail recipient does not have encryption, the system will provide direction through the process of receiving the e-mail. Users sending nonsecured e-mails containing EPHI to OHCA will receive a response advising them to seek secure methods for sending the information.

# Understanding Indian Health Services

Oklahoma is a combination of two Choctaw words and literally means “Red People.” Our state is home to 39 tribal governments, including 38 of the 561 tribes that are federally recognized. The 2000 Census indicated the tribal population in Oklahoma to be approximately 390,000.

Indian Health Services (IHS) is not an insurance plan. It is a “trust responsibility” of the federal government that was originally executed through the establishment of the IHS, a branch of the Department of Health and Human Services. This trust responsibility was later expanded to let tribes “compact” to run their own health care systems. There is no set benefit package or any mandatory benefits. Thus, an Indian facility may provide a single service, such as pharmacy, or may provide a wide variety of services including primary care, outpatient services, specialty care and inpatient services.

Indian health facilities are financially responsible only for the services provided onsite at their facilities, unless they have pre-existing contractual agreements with other health care facilities or pre-authorize a service through their contract health department. Thus, if an Indian person presents for care at a non-Indian facility, the facility will bill the patient directly unless the service has been pre-authorized including payment.

To qualify for services at a tribally run Indian health facility or an IHS facility, patients are generally required to have a card which verifies the certificate of degree of Indian blood (CDIB card). It is the responsibility of the facility to verify that a person has this card before providing treatment. This is a federal requirement.

In Oklahoma, if you have a CDIB card, you are eligible for treatment at most of the Indian health facilities. Only one facility, Bearskin Health Center in Wyandotte, restricts treatment to members of two specific tribes. Additionally, since Medicaid

is an entitlement program for U.S. citizens, if patients are both Indian and a U.S. citizen, they may also be eligible for Medicaid. Many Indians are also Medicare eligible and/or have private insurance.

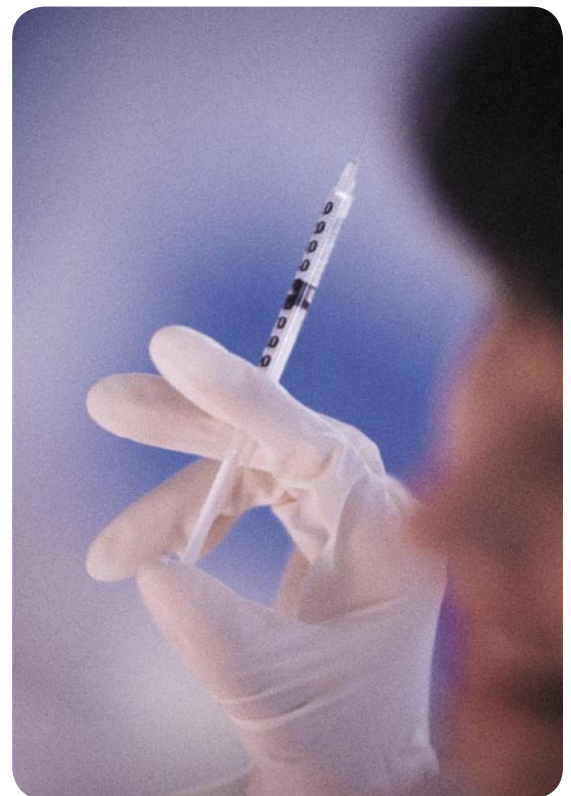
In the case of multiple payers, Medicare pays first, then private insurance, then Medicaid, then Indian Health. By federal law, Indian Health is always the payer of last resort. Indian Health facilities are allowed to bill both Medicare and Medicaid. Medicaid accounts for the bulk of IHS’ third-party revenues. However, because of the trust responsibility of the federal government, Medicaid payments for Indian Medicaid recipients seen in Indian facilities are paid for entirely by the federal government. No state dollars are used to pay for services for Indians who receive Medicaid compensable services in Indian Health facilities.

Tribal health care ranges from complex systems to small tribal clinics that include IHS facilities, Tribal Health facilities or Urban Indian Clinics. The role of IHS in Oklahoma has increasingly changed and diminished as some tribes have opted to manage individual tribal health care systems. None of these systems are exactly alike, and each system has different resources and financial support. In general, the onsite specialty care available at Indian Health facilities is extremely limited or non-existent.

The IHS directly employs more than 100 physicians in Oklahoma. Another 30 physicians are employees of various tribal administrations that are operated under the Indian Self Determination Act of 1975 (P.L. 93-638). Under this law, tribes can choose to compact their health programs. Eighty-five

percent of the doctors are either board certified in their specialty or have three to four years of residency training. All of the hospitals are JCAHO accredited, and most offer outpatient and inpatient services including general surgery, obstetrics/gynecology, internal medicine and pediatrics.

Subspecialty services such as orthopedics, gastroenterology and ENT are furnished through “contract health services” with private health care providers. At several locations, specialty programs are affiliated professionally with state medical schools. Medicaid is the largest source of third-party revenue for all Indian Health providers, and most facilities include an aggressive Medicaid outreach program in the business office functions. The federal government honors its treaties with Indian tribes by providing services to Indians through the Indian Health Service and by allowing state Medicaid programs to claim 100 percent federal match for core services provided at IHS, Tribal or Urban Indian clinics.





## Talk to me ...

Did you know that you can opt for hands-free communication when calling the Oklahoma Health Care Authority call tree? When asked to select “one” if calling from a touch-tone phone, do not select that option.

The automated voice response (AVR) system will then give the caller the opportunity to simply speak the preferred options rather than keying them through the touchpad. There is no difference in the options offered.

Callers still have the opportunity to select either Provider or Client options.

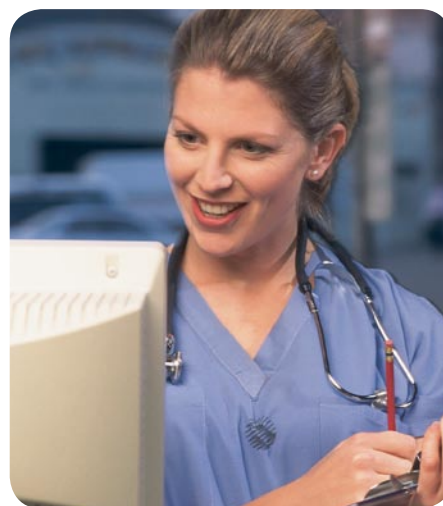
While some callers prefer the hands-free option, the AVR is rather sensitive. Sometimes AVR can pick up background noises in an especially busy or loud office and misinterpret those as selected options. If this happens, the AVR will ask “Did you mean ...?” so you can give further clarification.

## Medicaid on the Web Help Desk has new name

The Medicaid on the Web Help Desk has changed its name to the Internet Help Desk.

But don't worry – the Internet Help Desk's phone numbers and extensions are unchanged, and the support team is the same group of professionals that Medicaid on the Web users have come to rely on for fast, friendly answers to their technical questions.

The Internet Help Desk will be extending its technical assistance to Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC) users.



### OHCA Call Tree Options

Toll-free (800) 522-0114 • Oklahoma City area (405) 522-6205

Opt.	Unit	Call Types	Hours
1	EDS Call Center	Claim status, eligibility questions, client inquiries, basic policy questions, Spanish assistance	7:30 a.m. - 5:30 p.m. M-F
2	EVS Eligibility	Automated phone system	5 a.m. - 1 p.m. 7 days/week
3	Care Management	Care/Case Management, help finding specialists, out-of-state care, transplant care issues	8 a.m. - 5 p.m. M-F
4	Pharmacy Help Desk	Prescription drug claim and prior authorization issues	8:30 a.m. - 5:30 p.m. M-F
5	Provider Contracts	Contract issues, EFT issues, new fee-for-service contracts, issue prescriber numbers	8 a.m. - 4:30 a.m. M-F, closed 8 a.m. - 12 p.m. on W
6	Adjustments	Questions concerning paid claim adjustments, outstanding A/R inquiries	7:30 a.m. - 4 p.m. M-F, closed 8 a.m. - 12 p.m. on T
7	Third Party Liability	Health insurance injury/accident questionnaire, third party insurance queries, estate recovery, subrogation issues	8 a.m. to 5 p.m. M-F
8, 1	Internet Help Desk	Medicaid on the Web PIN resets, clerk setup assistance, assistance submitting claims, PAs, eligibility inquiries	8 a.m. - 12 p.m., 1 p.m. - 5 p.m. M-F
8, 2	EDI Help Desk	Batch transactions	8 a.m. - noon, 1 p.m. - 5 p.m. M-F
9, 1	Medical Authorizations	Prior authorization requests for DME, medical services, and emergency PAs for aliens	8 a.m. to 5 p.m. M-F
9, 2	Dental Authorizations	Prior authorizations for dental procedures	8 a.m. to 5 p.m. M-F



## Opportunities increase for providers to render family planning services through waiver program

The Oklahoma Health Care Authority (OHCA) has broadened the opportunities for Medicaid contracted providers to render and be reimbursed for family planning services through implementation of a waiver program earlier this year and instituting changes in another program.

### SoonerPlan (family planning services only)

The new waiver program, SoonerPlan, was implemented April 1, 2005, said LaDawn Fulgenzi,

provider services support supervisor. SoonerPlan recipients have a benefit package limited to family planning services only. These individuals do not receive the full scope of Medicaid services. These SoonerPlan individuals are not enrolled with a primary care provider/case manager, and a referral is not required in filing claims for them. Providers who serve individuals in SoonerPlan should bill using their fee-for-service provider numbers, not their **SoonerCare** provider ID, Fulgenzi added.

deliver family planning services to all **SoonerCare** members. To clarify further, **SoonerCare** members who see a provider other than their primary care provider/case manager (PCP/CM) for these services will not need a referral from the PCP/CM for the claims to be paid, Fulgenzi said.

In a recent program change, the PCP/CM is not penalized when members seek family planning services from someone other than the PCP/CM. OHCA made the change in accordance with the Medicaid managed care regulations, implementing certain provisions of the Balanced Budget Act of 1997. Prior to 2005, OHCA deducted a specified amount from a PCP/CM's capitation payments if a member age 18 or older received family planning services from a provider other than the PCP/CM. OHCA is preparing a mass adjustment to repay any PCP/CMs who had deductions for 2005 family planning services. The adjustment should be performed before the end of the year.



### Family planning self-referrals (for SoonerCare members)

Effective immediately, family planning is now a self-referral service in **SoonerCare**. Age restrictions that applied in the past have been removed. Any Medicaid provider may

*continued from page 3*

### Stimulant / ADHD Medications

- Tier-1 products are covered with no authorization necessary.
- Prior authorization is required for all stimulants / ADHD medications for clients age 21 and older.

#### Tier-2 authorization requires:

- Documented trial of a Tier-1 medication with inadequate results, or
- Documented adverse effect or contraindication to the Tier-1 products, or
- Documented FDA-approved indication for which Tier-1 products are not indicated.

#### Tier-3 authorization requires:

- Documented trial of two Tier-1 medications with inadequate results.
- Strattera is not covered simultaneously with any other Stimulant / ADHD medication.

#### Tier-1 (no PA required if under age 21)

amphetamine salt combo (Adderall)	methylphenidate ER (Metadate ER)
amphetamine salt combo (Adderall XR)	methylphenidate ER (Concerta)
dextroamphetamine (Dexedrine, Dextrostat)	
dexmethylphenidate (Focalin, Focalin XR)	
methylphenidate (Ritalin)	
methylphenidate SR (Ritalin SR)	

#### Tier-2 (requires PA)

atomoxetine (Strattera)
methylphenidate ER (Metadate CD, Ritalin LA)

#### Tier-3 (requires PA)

methamphetamine (Desoxyn)
pemoline (Cylert)

## Oklahoma residents enjoy benefits of a new Medicare health program for seniors

If you've struggled with helping your senior patients battle chronic illnesses such as diabetes and heart failure, a new program – Medicare Health Support – may be the tool you need to help them effectively manage their conditions. This new program, recently begun by Medicare and LifeMasters, offers participants health education, coaching and teaching on how to monitor their health.

Medicare Health Support is available to select Medicare beneficiaries at no cost. The program is not an HMO or a health insurance plan. Patients who enroll in the program will continue to see their

same provider and receive the same benefits, and their health care coverage will not change. The program will last for three years and then will

be evaluated by Medicare.

Medicare selects who is eligible to participate, and no self-referrals are accepted. The program is only for seniors who have traditional Medicare **and** have diabetes and/or heart failure.

Once enrolled in the program, participants are contacted by a LifeMasters nurse, who will develop a program customized to their needs. The nurses provide education about living with the individual's chronic

conditions, tracking important vital signs and symptoms, making better food choices, developing a suitable exercise program, learning the best ways to take their medications and, in general, avoiding situations that might make their conditions worse. Essentially, program participants get their own personal health coach, who helps them learn how to lead a healthier life.

While many Oklahoma residents are already benefiting from the program, many others who are eligible have not yet signed up. If one of your eligible patients has received a letter from LifeMasters and Medicare inviting them to participate in the program, please encourage them to do so. For additional information about Medicare Health Support and LifeMasters, call toll-free at 1-888-713-2837 or visit [www.lifemasters.com](http://www.lifemasters.com).

**Medicare Health Support is available to select Medicare beneficiaries at no cost.**

## OHCA policy change allows hospice coverage for children

The Oklahoma Health Care Authority (OHCA) has developed a policy that allows for the payment of hospice services for children who have been certified by their physician as having a terminal illness and a life expectancy of less than six months. The policy, which went into effect Aug. 1, 2005, provides Medicaid reimbursement for home-based hospice services to eligible individuals younger than age 21.

The certification process for this additional care requires contracting with the OHCA as a hospice provider. Contracts are available on the OHCA Web site at [www.okhca.org](http://www.okhca.org). Under the Provider box, select Enrollment. Under New Contracts, scroll to Hospice contract. Interested providers will need to complete a printed copy of the contract and submit it to OHCA for approval. This contract is separate from the Advantage Waiver

Program Contract. Questions may be directed to the Contract Services Unit (405) 522-6205, option 5. The new rules can be viewed on the OHCA Web site under the Provider box, then Policy & Rules, then OHCA Rules, then Chapter 30, then Subchapter 5, then Part 59.

Paperwork required for prior authorization includes:

- HCA 12-A – signed by physician or hospice medical director.
- Physician certification – signed by the client's physician.
- Interdisciplinary Plan of Care – signed by physician or hospice medical director.

Clients and family members may call the OHCA Care Management Unit at 1-877-252-6002 if they have questions concerning services and eligibility under the new policy.



# New Medicaid program for children with severe disabilities begins

County offices of the Oklahoma Department of Human Services (OKDHS) began accepting applications Oct. 1, 2005, for TEFRA (Tax Equity and Fiscal Responsibility Act), a new Oklahoma Health Care Authority program that may allow children with severe disabilities who previously were ineligible for Medicaid to now qualify.

TEFRA makes benefits available for children with physical or mental disabilities who would not ordinarily be eligible for Supplemental Security Income (SSI) benefits because their parents' income or resources were too high. Under TEFRA, only the child's income and resources are counted.

Before the program was even implemented, almost 200 families had expressed interest in the program, which was recently approved by the federal Centers for Medicare & Medicaid Services. Within the first week, 15 applications had been submitted and are currently being processed. Two of those are close to being certified, said former TEFRA project coordinator Dan Alcorn.

"We've been working on this new program for over a year and are excited to be this close to getting someone certified," Alcorn said. In the weeks before launching the new

program, he and other OHCA staff members conducted many outreach meetings with parents of children with disabilities, the United Cerebral Palsy group in Tulsa, the recent Respite Conference and various advocacy groups to educate people about the program. Letters explaining TEFRA were also sent to 700 families who may be affected by the new eligibility guidelines.

To be eligible for TEFRA, a child must meet income guidelines, be younger than age 19, live at home, meet the Social Security Administration's definition of disability and require an institutional level of care. Also, it must be appropriate to provide care at home, and the cost of care can't exceed the estimated cost of treating the child in an institution.

Children who qualify for TEFRA will receive the full scope of Medicaid services, such as inpatient and outpatient treatment, prescription drugs, occupational and physical therapy and medical equipment. Applications are being accepted through OKDHS.

Once OKDHS has performed initial processing of the application, OHCA's Level of Care Evaluation Unit ensures that the child has a

valid determination of disability and evaluates the institutional level of care. The next step is a cost effectiveness review. If all requirements are met to this point, an onsite visit is made by a nurse from the Long Term Care Authority to evaluate the safety and appropriateness of caring for the child in the home.

If the home visit results are favorable, the Level of Care Evaluation Unit recommends certification of the child's case to the OKDHS worker.

TEFRA children receive a new member orientation call from a dedicated Beneficiary Program Coordinator, who also assists with enrollment of the child with a *SoonerCare* primary care provider/case manager. Children who have private HMO coverage will not be enrolled in *SoonerCare*.

In addition, a registered nurse exceptional needs coordinator will also contact the family to review the member's needs and assist with any specialty care alignment.

For more information about the TEFRA program, call Frank Gault with OKDHS at (405) 521-4394 or visit [www.okhca.org](http://www.okhca.org).

## New OHCA Web site offers more

The Oklahoma Health Care Authority (OHCA) launched its new Web site – [www.okhca.org](http://www.okhca.org) – in September, with expanded services and resources for providers and enrollees. The new site is designed to be user friendly and easy to navigate. Providers will find timely information specific to their specialties, such as rules, manuals, prior authorization, forms and contracts for enrolling in the Oklahoma Medicaid program.

An exciting feature of the new site is online training videos for busy providers and staff unable to attend

training sessions, such as Medicaid 101, *SoonerCare* and others. Providers can also see what training sessions are being offered in Oklahoma City and Tulsa, print registration forms and take advantage of other training resources.

The member area includes expanded information on available programs, forms, eligibility requirements and general health information. Providers can direct patients to this site for information and may find it helpful for their own staff to review.

Banners on the main page feature programs OHCA is currently promot-

ing. Press releases are added regularly, and visitors to the site can read various publications and reports.

The Oklahoma Medicaid Management Information System (OKM-MIS) – Medicaid on the Web – is still available through this new Web site. Medicaid on the Web service has been upgraded with new hardware, and service is faster than ever.

OHCA welcomes feedback on the new architecture of its Web site. Viewers can send comments and even ask questions by clicking on "site comments."

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Please submit any questions or comments to Meri McManus in the Oklahoma Health Care Authority's Public Information Office at 405.522.7026.



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