Fall 2005
Provider Update
A publication of the Oklahoma Health Care Authority

OHCA Board approves physician rate increases

Medicaid providers will benefit from a rate increase approved by the Oklahoma Health Care Authority's (OHCA) Board recently. The board voted to increase the Oklahoma Medicaid physician fee schedule to 100 percent of the Medicare rate, effective Aug. 1.

The vote was taken after the OHCA board heard a recommendation from the Committee on Rates and Standards to increase the rate for services provided to children and adults in the state's Medicaid program. The purpose of this action is to ensure Medicaid children receive prompt access to health care.

House Bill 1088 provided $25 million in funding to the agency to increase provider reimbursement for Medicaid services and Medicare co-insurance and deductible payments for state fiscal year 2006. An estimated 8,700 providers will be affected by the rate increase.

Additional Board Action

An estimated 27,000 adult Oklahomans may be affected by another decision of the Board to remove the marriage penalty from the Medicaid eligibility rules. Under the current rules, in a household where both parents are present and neither is disabled, neither parent is eligible for Medicaid regardless of their income unless one parent leaves the family. Eliminating the marriage rule will allow parents of Medicaid-eligible children to receive health care coverage when the total household income is under 35 percent of the Federal Poverty Level for a family of three; that equates to $471 per month.

Agency staff estimated an annual total cost of $3.6 million with a state share of approximately $1 million. The rule change will become effective when it is signed by the Gov. Brad Henry or Sept. 1, whichever is later.

SoonerCare case renewals can be made by phone

Due to a recent change in policy by the Oklahoma Department of Human Services (OKDHS), *SoonerCare* enrollees who have no other OKDHS coverage (food stamps, child care, etc.) can now renew their eligibility for *SoonerCare* services simply by speaking to their caseworker by phone. A face-to-face visit is not required to review their case for *SoonerCare* eligibility.

Reviews for other types of OKDHS assistance still require a personal visit with a caseworker to complete required forms and provide necessary information.

SoonerCare providers may encourage any patient whose card indicates they are no longer eligible for services to call their social service specialist for a case review by phone.

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Oklahoma Health Care Authority

DUR Newsletter

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Drug Utilization Review for Oklahoma Medicaid

To decrease the amount of material in your inbox, OHCA has incorporated the DUR Newsletter into Provider Update.

CME programs available through Epocrates

Now, not only can you download the OHCA preferred drug list from Epocrates, you can download CME programs as well.

Overworked? Always on the go?

If you are short on time, you'll really appreciate the convenience of the new MobileCME solution from Epocrates.

The MobileCME on-the-go learning system is a **FREE** service that enables you to earn CME credits on your mobile device, wherever you are, whenever you have time. This unique product, specifically designed for on-the-go clinicians, makes it easy to stay abreast of important medical developments in your field and satisfy your continuing medical education requirements in your downtime.

How Does It Work?

1. Receive CME programs in your chosen specialties when you Auto Update (sync while connected to the Internet).
2. View credit statement, faculty information and learning objectives for a program before you start.
3. Read articles formatted for the PDA screen and then answer multiple-choice questions.
4. AutoUpdate to send your completed program information to Epocrates.
5. A certificate will be emailed to you.

Check out www.epocrates.com for more information.

If you would like training on Epocrates, please contact our pharmacy trainer at (405) 522-7141 or rxtraining@ohca.state.ok.us.

DUR Medicare reminder

As a reminder, the Medicare Part D Prescription Drug benefit takes effect Jan. 1, 2006. At that time, individuals who are eligible for both Medicaid and Medicare will begin to receive their prescription drug benefit from Medicare instead of Medicaid.

The Oklahoma Health Care Authority encourages providers, especially pharmacies and primary care providers, to ask their patients (1) whether they are enrolled in Medicare, (2) if they have received their Part D information (after Oct. 1) and (3) to bring the Part D information to the provider as soon as they have received it so that their medical records can be updated.

CMS has a new web page dedicated to retail pharmacy issues surrounding Part D. The web address is http://www.cms.hhs.gov/medicarereform/pharmacy/.

For people on Medicare, open enrollment begins Nov. 15, 2005, and runs through May 15, 2006. Beneficiaries can get more information by calling 1-800-MEDICARE.

New DUR Board meeting dates

The meeting dates for the Drug Utilization Review Board have changed to the second Wednesday of each month.

The new dates for the rest of 2005 are:

- Wednesday, September 14
- Wednesday, October 12
- Wednesday, November 9
- Wednesday, December 14

Drug Utilization Review helpful hints ...

- Please note that there are now several different types of override prior authorizations (PAs) available, including early refill, quantity limit and brand only (DAW), as well as an override of the three brand drugs per month limit if the client is Waiver and is enrolled in the Pharmacotherapy Management Program. Each of these overrides (with the exception of the early refill) requires a different override PA request form. For an early refill request, contact the pharmacy help desk. Please be sure to use the correct form when requesting an override. The forms are all available online at http://www.ohca.state.ok.us/provider/pharmacy/billing/forms.htm. Call the pharmacy help desk for assistance in determining why a claim is not running and which override type may be applicable.
- If a prior authorization request is not approved, the PA unit makes every effort to ensure that there is a reason provided, often with details about what further information is needed. Be sure to read these messages, usually found on the third page of the fax returned to the pharmacy, and forward them to the prescriber if necessary, since these messages are faxed out from Medicaid to the pharmacy only. Please do not send duplicate PA petitions without the additional information requested.
- For efficient processing of prior authorization requests, include all information about any special circumstances the client may have that you believe should be considered by the PA unit when deciding whether to approve the PA request. If complete information is provided on the first PA request, it can save providers the time and effort of making repeat PA requests or calling the pharmacy help desk.

New help desk hours

The hours for the Pharmacy Help Desk have changed.

Beginning July 1, 2005, our hours changed to the following:

Monday through Friday – 8:30 a.m.- 7 p.m.
Saturday – 9 a.m.- 5 p.m
Sunday – 11 a.m.- 5 p.m.

Recent additions to quantity limits

Antidepressants	
Drug	**Quantity Limits**
Bupropion (**Wellbutrin**) tablets	3 units per day up to 100 units
Bupropion (**Wellbutrin SR**) *sustained release tablets*	2 units per day up to 100 units
Bupropion (**Wellbutrin XL**) *sustained release tablets*	1 unit per day up to 100 units
Citalopram (**Celexa**) tablets	1 unit per day up to 100 units
Duloxetine (**Cymbalta**) capsules	20 mg – 2 units per day 30, 60 mg – 1 unit per day up to 100 units
Escitalopram oxalate (**Lexapro**) tablets	1 unit per day up to 100 units
Fluoxetine (**Prozac**) capsules/tablets	1 unit per day up to 100 units
Fluoxetine (**Prozac Weekly**) *90 mg capsules*	4 caps (1 pack) per 28 days
Fluvoxamine (**Luvox**) tablets	25 mg – 1 unit per day 50 mg – 2 units per day 100 mg – 3 units per day up to 100 units

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OHCA addresses health care disparities

Last year, Oklahoma was one of 12 states selected to participate in a quality improvement initiative through the Center for Health Care Strategies (CHCS) Purchasing Institute, "Leveraging Data to Reduce Racial and Ethnic Health Disparities." At the same time, ***SoonerCare*** was selected to participate in the CHCS Best Clinical and Administrative Practices (BCAP) work group "Improving Health Care Quality for Racially and Ethnically Diverse Populations in Medicaid Managed Care." This is a 24-month project.

As a participant in the BCAP work group, the agency's Quality Assurance/Improvement and ***SoonerCare*** and Care Management staff have worked in collaboration with CHCS and health plans from other states since October 2004 to initiate and develop the evaluation design "Diabetic Management of the Racially and Ethnically Diverse Population of a Statewide, Medicaid Partially Capitated Primary Care Case Management Program."

Partnering with appropriate stakeholders (consumers, providers and state purchasers), they have developed an objective and a plan to evaluate health care disparities that may be associated with the racially and ethnically diverse population of the statewide ***SoonerCare*** managed care program.

They have focused on improving the effectiveness and level of care for adult American Indian enrollees identified with a diagnosis of diabetes. The project includes:

- Identification of areas of potential health disparities in the SoonerCare adult population with a diagnosis of diabetes.
- Development of an intervention program designed to target adult SoonerCare enrollees diagnosed with diabetes.
- Development of an educational program designed for clinical practice settings.
- Ongoing measurement, evaluation and reporting of intervention activities to OHCA and CHCS.

The American Indian enrollees are provided health care services either through the traditional ***SoonerCare*** program or through the voluntary American Indian ***SoonerCare*** program. The provider network for the American Indian program is composed of IHS, Tribal and Urban Indian clinics. Staff members are currently evaluating the health services of American Indian adults cared for through both systems. They have already identified four "high-performing" provider sites for assessment and education and will evaluate identified providers to determine best practices and educational needs. The results of those assessments will be used to provide education sessions at four identified "low-performing" practice sites.

Part of a multi-tiered initiative, CHCS works with state Medicaid agencies to enhance data collection and analysis skills, build agency capacity and create a strategic plan for quality improvement projects focused on health disparities. Using the BCAP Quality Framework, Quality Assurance/Improvement, ***SoonerCare*** and Care Management staff have been able to target quality improvement resources effectively with outcomes expected to produce measurable results.

CMS approval opens door to Oct. 1 launch date for TEFRA

The Oklahoma Health Care Authority has received an approval letter from the Centers for Medicare & Medicaid Services for SPA-OK-05-02 TEFRA (Tax Equity and Fiscal Responsibility Act), bringing Oklahoma one step closer to providing Medicaid benefits to children with severe disabilities who were previously ineligible for such aid.

Since eligibility for TEFRA benefits is based only on the child's income and resources, it will make 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 are too high.

To be eligible for TEFRA, a child must:

- Be younger than age 19.
- Be a resident of Oklahoma.
- Be a U.S. citizen or qualified alien.
- Provide a Social Security number.
- Meet the SSI definition of disability.
- Meet income guidelines. (For 2005, the child must have a monthly gross income at or below $1,737 and countable resources at or below $2,000.)
- Meet an institutional level of care.

The three levels of care are:

- Intermediate care for the mentally retarded (ICF-MR).
- Nursing facility (skilled or intermediate care).
- Hospital care.

Meeting a level of care does not mean a child has to be institutionalized.

Also, it must be appropriate to provide care to the child at home, and the estimated cost of caring for the child at home cannot exceed the estimated cost of treating the child in an institution.

TEFRA 134 Children, which is funded by money generated through Oklahoma's new tobacco tax, will go into effect Oct. 1, 2005. Through this program, eligible children with special health care needs or disabilities will receive the full scope of Medicaid services, which include but are not limited to inpatient and outpatient treatment, pharmacy, occupational and physical therapy, non-emergency transportation, medical equipment and Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT).

Oklahoma Health Care Authority

OHCA MMIS NEWS

Beginning with this issue, OHCA will be incorporating the MMIS Newsletter into Provider Update.

Most common Medicare crossover claims errors

Periodically, EDS reviews different claim types to determine where additional provider education may be needed. EDS recently reviewed the errors providers are getting on Medicare crossover claims that have been received both automatically and in paper format. Below is a list of the most common errors and how to avoid them.

Problem: The Medicare Explanation of Medical Benefits (EOMB) indicates it should have crossed over to Medicaid, but it never appears on the remittance advice (RA).

Education: The Medicaid Management Information System (MMIS) maps the provider's Medicare number to the Medicare number associated with the 10-character Medicaid provider ID. If the Medicare number that is on the electronic claim is not on file with the Oklahoma Heath Care Authority (OHCA), the claim will deny for provider number not on file. The provider will never see this claim on their RA as the system is unable to make a match. The claim will also not appear on Medicaid on the Web.

Correction: Call the OHCA call tree and choose option 1. Provide the claim information that appears on the EOMB that indicates the claim was forwarded to Medicaid. The call center representative will locate the claim in the system by client ID, procedure code and date of service. If the claim denied for no match to the provider ID, the caller will be transferred to Provider Contracts to have the appropriate Medicare number added to their Medicaid provider file.

Problem: Automatic crossovers or paper crossovers are denying because the provider is unable to be the billing provider.

Education: Providers are assigned one of two billing types: a billing provider or non-billing provider. A good example of this can be found in a clinic. The clinic is the billing entity, as payments are set up to go to the clinic's Federal Employer Identification Number (FEIN). The physicians who work in the clinic are non-billing providers. Since the clinic's provider FEIN is the billing provider and the physicians associated with the clinic are rendering or non-billing providers, the clinic is recognized by the billing indicator as the only provider able to bill and receive payment. This is why crossovers deny when submitted incorrectly under the physician's provider number. This separation into billing and non-billing provider types was created to prevent many providers from billing incorrectly resulting in having payments appearing as income under the incorrect tax ID.

Correction: If the denial is a result of the billing indicator being set to "No," the billing provider's file needs to be corrected to reflect the appropriate Medicare or Medicaid provider number. For questions concerning whether or not the appropriate billing indicator is set up correctly, please contact Provider Contracts toll free at (800) 522-0114, option 5 or locally at (405) 522-6205, option 5.

Problem: Receiving a lot of claim denials for exact duplicates.

Education: EDS receives crossover claims from many intermediaries and the tapes are not always received on a timely basis, or may not be readable. If this occurs, EDS requests a new tape from the intermediary. Most intermediaries submit the claims to Medicaid within 30 days to 45 days.

Correction: Wait at least 45 days from the date of the Medicare EOMB prior to dropping the claim to paper. This should save on the cost for paper, postage and the time associated with reconciliation of the remittance advice.

OHCA's positions on third party liability payments and allowable charges to Medicaid clients

In light of a recent Oklahoma Attorney General's opinion cited as 05-004 (2005) and the ongoing confusion of 42 CFR § 447.20, the Oklahoma Health Care Authority would like to reiterate its position regarding third party liability payments.

Medicaid providers are prohibited from billing a Medicaid recipient and his/her financially responsible representative when a third party is liable for an amount that is greater than or equal to the amount that would have been paid by OHCA. This section applies to Medicaid compensable services only. Providers are contractually bound by this limitation even if they do not bill OHCA. A provider may not refuse to furnish services to a Medicaid-eligible individual because a third party is involved. Payment made by OHCA is considered payment in full, and a provider may not bill the recipient for an amount in excess of the Medicaid allowable. A provider should only bill a recipient for a co-payment or cost-sharing payment that is imposed by OHCA. However, the provider may continue to bill the recipient and his/her financially responsible representative for Medicaid noncompensable items.

Providers who seek to collect an amount greater than the Medicaid allowable from a recipient may be subjected to penalties pursuant to 42 CFR §447.21. Penalties can be a reduction in Medicaid payments due the provider, which is equal to three times the amount the provider sought to collect.

If the third party source pays less than the Medicaid allowable, you may bill OHCA for the remaining balance. The current TPL system pays claims based on the coverage type of the third party. If the third party is an HMO, OHCA will pay an HMO co-pay with built-in maximum limitations, PPO coverage will result in payment of the Medicaid allowable minus the third party payment, and Medicare crossovers will pay co-insurance and deductibles for traditional Medicare Fee-for-Service claims. Casualty claims will pay the Medicaid allowable minus the third party payment.

"Payment made by OHCA is considered payment in full."

If you have any questions regarding whether a service is covered or how and when to file a claim to avoid a possible penalty, call (800) 522-0114 and ask for customer service.

Don't be a no-show Jones

As we meet with health care providers in training sessions through the year, we hear comments like "I wish you had training more often" or "I wish you did training sessions in our town." OHCA and EDS always consider those provider concerns and suggestions as we plan training each year.

One way you can help OHCA and EDS is by canceling registrations as soon as you realize you won't be able to attend a training session. This allows us to offer sessions to those on the waiting list or to cancel any sessions that don't have the minimum attendance.

All training for Medicaid providers is free to those attending, including the monthly Medicaid 101 classes and bi-annual provider training sessions. When a provider signs up for a class and confirmations are sent, EDS and OHCA prepare for the total number of confirmed attendees by printing handouts and assigning staff to assist with sessions.

Problems arise when individuals confirmed to attend the training fail to appear. Some of the recent training sessions have had as great as a 50 percent no-show rate. The extra materials and staff were available and not needed, wasting your tax dollars and resources.

Help us eliminate unnecessary travel, reduce expenses and ensure that training is held where providers most need it. Don't be a "no-show Jones!"

Change in acute care inpatient reimbursement

On July 22, 2005, the Oklahoma Health Care Authority (OHCA) in cooperation with the Oklahoma Hospital Association, Electronic Data Systems and APS, conducted a DRG Technical Conference.

This conference provided hospitals affected by the upcoming change in reimbursement methodology from per diem to DRG (Diagnosis Related Groups) an opportunity to receive advance information and to ask questions for clarification prior to the implementation. Ninety percent of the 247 individuals registered for the conference attended.

An updated slide show has been loaded onto the OHCA Web site, along with frequently asked questions (FAQ) from the conference. Please refer to the Web site to receive the most up-to-date information at www.ohca.state.ok.us. OHCA, EDS and APS are researching some questions. Those responses will also be included on the question and answer page.

DRG reimbursement methodology

Oct. 1, 2005, is the anticipated start date of the DRG reimbursement methodology for specified inpatient acute care hospitals. Hospitals that will begin receiving DRG payment for inpatient services are those that have a provider type of Hospital and the licensed specialty of Acute Care or Critical Access Care associated with the Medicaid provider number.

Providers who don't know the provider type and specialty of their facility should call (800) 522-0114, option 5, or (405) 522-6205, option 5, for that information.

All other providers that have the provider type of 01 – Hospital but have the provider specialty of 011 – Psychiatric, 012 – Rehabilitation, or 013 – Residential Treatment Center will continue to be reimbursed by a per diem.

The DRG reimbursement will be implemented based upon admission dates on or after Oct. 1, 2005. Claims with admission dates on or before Sept. 30, 2005, will be reimbursed by per diems, and the 24-day limitation will continue to apply.

Claims paid by the DRG reimbursement will be based on each admission through discharge. Interim billing will not be available through this reimbursement methodology. In addition, if a patient is transferred to another hospital, then each hospital will receive DRG reimbursement for the specified admit through discharge at each facility.

Oklahoma Medicaid will use the CMS Grouper Version 22, with an enhanced neonatal logic. The enhanced neonatal logic has been adopted to allow for the special needs of this population. The neonatal logic is based upon the baby's weight identified through diagnosis coding.

Providers who will be converting to the DRG reimbursement will receive a letter sometime after Sept. 1, 2005, indicating the peer group assignment and the hospital specific cost-to-charge ratio that will be used in an outlier calculation.

The basic calculation for Oklahoma Medicaid Inpatient DRG is:

> DRG Weight **x** Provider Peer Group Base Rate **+** Outlier Amount **–** Applicable co-payments and/or TPL **=** Reimbursement

If a claim's DRG reimbursement is less then $50,000 of the hospital cost, then the claim will be put through the outlier calculation to see if additional reimbursement is warranted. The outlier formula is:

> (Claim total amount billed **x** billing provider's cost to charge ratio) **–** (DRG weight **x** Peer Group Base Rate) **–** threshold amount **x** marginal cost factor **=** outlier amount, if greater than zero.

Claims will continue to be received in the same format, as there will be no changes to the paper UB92 claim form, direct data entry (Medicaid on the Web) or the 837I. If a provider's facility places the DRG on a claim when submitted, it will not be used in the claim processing or pricing components as the Medicaid Management Information System (MMIS) will price utilizing its programming.

One change that will be noticed is on the paper Remittance Advices on the Paid Inpatient Claims Paid page will indicate the DRG and the DRG weight. The DRG and weight will also be located in the 835 in Loop 2100. The DRG Code will be in CLP11, and the DRG weight will be in CLP12.

Please monitor the OHCA Web site, www.ohca.state.ok.us, for more DRG information.

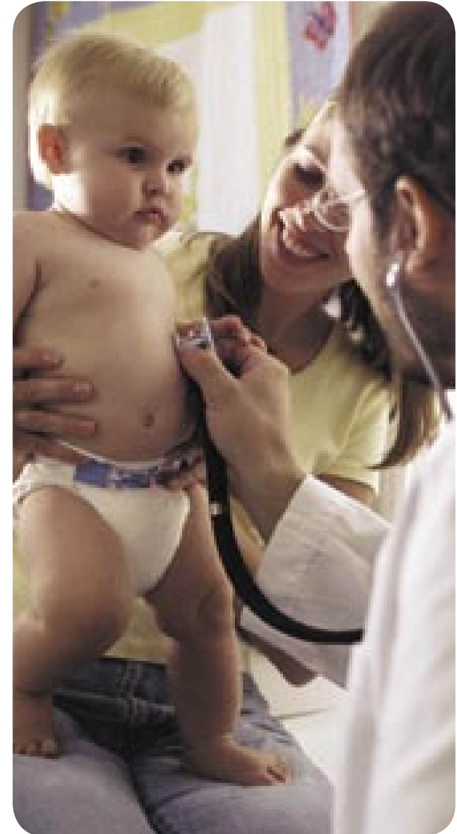
Earn bonus with back-to-school immunizations

As Oklahoma children head back to school this fall, be sure to remind parents to make appointments for the necessary immunizations for their children. You also can encourage them to bring in younger siblings for their immunizations at the same time. (The bonus payments are strictly for children age 2 and younger.)

This should also be a busy time for completing child health checkups (EPSDT exams). Screening, vision, hearing and dental services are all covered through the Early and Periodic Screening, Diagnosis and Treatment program, and catching problems early in these areas can help children perform better in school.

Children need to get regular checkups, even through their teenage years, to help them stay healthy. Seeing a health care provider on a regular schedule, even when feeling well, may help prevent serious health problems in the future. Anyone, age 20 or younger, who is enrolled in Oklahoma Medicaid should take part in these preventive health care services.

The table below shows the recommended exam schedule.



Recommended Child Health Check-ups

Babies	Toddlers	Children	Teenagers and older
• Birth • 2 months • 4 months • 6 months • 9 months • 12 months	• 15 months • 18 months	• 2 years • 3 years • 4 years • 5 years	• Every other year until 21 years old.

Oklahoma premium assistance program awaits federal approval

The Oklahoma Health Care Authority is currently seeking approval from the federal government to provide premium assistance to Oklahoma's low-income individuals and small businesses for health care coverage.

The proposal was submitted to the Centers for Medicare & Medicaid Services (CMS) under the Health Insurance Flexibility and Accountability Demonstration Initiative. OHCA was authorized to initiate the program based on measures passed last year by Gov. Brad Henry and the state legislature to increase access to affordable health coverage.

The program, authorized by the Oklahoma Health Care Recovery Act, will be implemented in two phases. In Phase I, the Premium Assistance Partnership Program, newly named the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC), will be offered to small business owners (with 25 or fewer workers) who want to provide their employees and their employees' families with private health insurance.

Initially, premium assistance will be available for workers and spouses with household incomes at or below 185 percent of the federal poverty level. Participating employers and employees will be required to pay a portion of the premiums. Employees will also be responsible for any applicable deductibles and co-payments. The premiums will be paid as follows:

- **Employer** ...... 25 percent of employee premium
- **Employee** ...... 15 percent of premium
- **State** .... 60 percent of premium
- **Spouse** ...... 15 percent of premium
- **Employer** none
- **State** 85 percent of premium

The state plans to devote an average of $50 million per year to the initiative, money that will be generated through the new tobacco tax, which took effect Jan. 1. Subject to approval from the federal government, the state's subsidy will be matched each year with approximately $100 million in federal funds.

Phase 2, the Premium Assistance Public Program, also includes a safety-net option for eligible workers and spouses whose employers are unable or unwilling to participate in the program. These individuals, as well as the self-employed and unemployed, will be permitted to buy directly into a product offered by the state. The program will also offer assistance to certain disabled individuals.

"Our goal is to have this program (Phase I) operational by fall 2005," said OHCA CEO Mike Fogarty.

Oklahoma has one of the highest uninsured rates in the country. In 2003, 20.4 percent of the state's residents were uninsured, as compared with 15.2 percent of the U.S. population. The 2004 Oklahoma Health Care Insurance and Access Survey found that 23.1 percent of adults ages 19-64 in Oklahoma were uninsured.

When the program is fully operational, the agency expects to enroll up to 70,000 Oklahomans based on the current funding.

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Antidepressants (continued)

Drug	Quantity Limits
Mirtazapine (**Remeron**) *tablets and SolTabs*	1 unit per day up to 100 units
Paroxetine (**Paxil**) tablets	1 unit per day up to 100 units
Paroxetine CR (**Paxil CR**) tablets	1 unit per day up to 100 units
Sertraline (**Zoloft**) tablets	2 units per day up to 100 units
Venlafaxine (**Effexor, Effexor XR**) *extended release capsules*	1 unit per day up to 100 units

Antipsychotics

Drug	Quantity Limits
Aripiprazole (**Abilify**) *5, 10, 15, 20, 30 mg tablets*	1 unit per day up to 100 units
Olanzapine (**Zyprexa, Zyprexa Zydis**) *2.5, 5, 7.5, 10, 15, 20 mg tablets & 5, 10, 15, & 20 mg orally disintegrating tablets*	1 unit per day up to 100 units
Olanzapine / Fluoxetine (**Symbyax**) *6/25, 6/50, 12/25, & 12/50 mg capsules*	1 unit per day up to 100 units
Quetiapine (**Seroquel**) *25, 100, 200, & 300 mg tablets*	25 mg,100 mg, & 200 mg – 3 units per day 300 mg – 2 units per day up to 100 units
Risperidone (**Risperdal, Risperdal M-Tab**) *0.25, 0.5, 1, 2, 3, & 4 mg tablets & 0.5, 1, & 2 mg orally disintegrating tablets*	2 units per day up to 100 units
Risperidone (**Risperdal Consta**) *25, 37.5, & 50 mg vial dose packs*	2 dose packs per 28 days (dose pack contains powder prefilled syringe & 2 mL of diluent)
Ziprasidone (**Geodon**) *20, 40, 60, & 80 mg capsules*	2 units per day up to 100 units

Controlled Substances

Drug	Quantity Limits
Butorphanol (**Stadol**) nasal spray	10 mL per 30 days (four 2.5 mL bottles = 100 sprays total)
Carisoprodol (**Soma**) 350 mg tablets	120 tablets per 30 days
Fentanyl transdermal (**Duragesic**) *25, 50, 75, & 100 mcg/hr patches*	25, 50, & 75 mcg- 10 patches per 30 days 100 mcg – no limit
Fentanyl oral transmucosal (**Actiq**) *200, 400, 600, 800, 1200, 1600 mcg lozenges*	120 lozenges per 30 days
Hydromorphone (**Dilaudid**) *2, 4, & 8 mg immediate release tablets*	2 or 4 mg – 180 tablets per 30 days 8 mg – 120 tablets per 30 days
Hydromorphone (**Palladone**) *12, 16, 24, & 32 mg extended release capsules*	30 capsules per 30 days
Meperidine (**Demerol**) *50 & 100 mg tablets*	60 tablets per 30 days
Methadone (**Dolophine**) *5, 10, & 40 mg tablets*	240 tablets per 30 days
Morphine sulfate (**Avinza**) *30, 60, 90, & 120 mg extended release capsules*	30 capsules per 30 days
Morphine sulfate (**Kadian**) *20, 30, 50, 60, & 100 mg sustained release capsules*	60 capsules per 30 days
Oxycodone / ibuprofen (**Combunox**) *5 / 400 mg tablets*	28 tablets per 30 days

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Controlled Substances (continued)	
Drug	**Quantity Limits**
Oxycodone (**Oxy IR**) *5, 15, & 30 mg immediate release tablets & capsules*	240 tablets/capsules per 30 days
Oxycodone (**OxyContin**) 10, 20, 40, & 80 mg *controlled release tablets*	10, 20, 40 mg – 60 tablets per 30 days 80 mg – no limit
Eszopiclone (**Lunesta**) *1, 2, & 3 mg tablets*	30 tablets per 30 days
Zaleplon (**Sonata**) *5 & 10 mg capsules*	30 capsules per 30 days
Zolpidem (**Ambien**) *5 & 10 mg tablets*	5 mg – 60 tablets per 30 days 10 mg – 30 tablets per 30 days
Stimulants	
Drug	**Quantity Limits**
Amphetamine Salt Combo (**Adderall XR**) *5, 10, 15, 20, 25, & 30 mg extended release capsules*	30 capsules per 30 days
Dexmethylphenidate (**Focalin XR**) *5, 10, & 20 mg extended release capsules*	30 capsules per 30 days
Methylphenidate (**Concerta**) *18, 27, 36, & 54 mg extended release tablets*	18, 27, & 54 mg: 30 tablets per 30 days 36 mg: 60 tablets per 30 days
Methylphenidate (**Metadate CD**) 10, 20, & 30 mg *extended release capsules*	10 & 20 mg: 30 capsules per 30 days 30 mg: 60 capsules per 30 days
Methylphenidate (**Ritalin LA**) *20, 30, & 40 mg extended release capsules*	20 & 40 mg: 30 capsules per 30 days 30 mg: 60 capsules per 30 days
Modafinil (**Provigil**) *100 & 200 mg tablets*	30 tablets per 30 days
Injectibles	
Drug	**Quantity Limits**
Insulin	4 vials (40 mL) per 30 days
Anakinra (**Kineret**) *100 mg / 0.67 mL prefilled syringes*	28 syringes per 28 days (18.76 mL / 28 days)
Dalteparin (**Fragmin**) *2500, 5000, 7500, 10000, 25000 U single-dose pre-filled syringes*	30 doses per 30 days (qty limit in mL varies by strength, ranging from 3.8 to 9.5 mL per 30 days)
Darbepoetin alfa (**Aranesp**) *25, 40, 60, 100, 150, 200, 300, 500 mcg single-dose vials & pre-filled syringes*	4 vials or syringes per 30 days (vials contain 1 mL; for syringes, number of mL per syringe & qty limit in mL varies by strength)
Enoxaparin (**Lovenox**) *30, 40, 60, 80, 100, 120, & 150 mg single-dose pre-filled syringes*	60 doses per 30 days (number of mL per syringe & qty limit in mL varies by strength, ranging from 18 to 100 mL per 30 days)
Filgrastim (**Neupogen**) *300 mcg/mL & 480 mcg/1.6 mL single-dose vials and 300 mcg/0.5 mL & 480 mcg/0.8 mL pre-filled syringes*	30 doses per 30 days (qty limit in mL varies by strength, ranging from 15 to 48 mL per 30 days)
Fondaparinux (**Arixtra**) *2.5, 5, 7.5, 10 mg single-dose pre-filled syringes*	30 doses per 30 days (number of mL per syringe & qty limit in mL varies by strength, ranging from 12 to 24 mL per 30 days)
Glatiramer (**Copaxone**) kit *thirty 20 mg 1-mL single-use syringes*	1 kit per 30 days
Interferon beta-1a (**Rebif**) *8.8, 22, & 44 mcg single-use pre-filled syringes*	12 doses per 30 days (qty limit in mL varies by strength, ranging from 4.2 mL/30 days to 6 mL/28 days)

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Certified Nurse's Aide Pilot Program off to a strong start

Candidates have been plentiful for a new pilot program to certify nurse's aides to work at long-term care facilities. As of July 25, 52 students have graduated from the program, which was launched the week of May 23. Another 34 are currently taking the classes, with 23 more enrolled for future classes.

"We've had a great response since we opened the classes for enrollment in May. As soon as one class graduates, another one begins," Project Manager Teri Dalton said. "Word is getting out about the program, and classes are filling up. And the classes are very family oriented. We're seeing family members enrolling and attending together.

"The program has gone very well, and Oklahoma State University-Oklahoma City has been wonderful to work with. Nursing instructors are taking a real interest in the students, and that is so important. When the students see that they are valued by the nurses, it makes a major impact on their career choice and builds a very good foundation for future working relations."

Despite the early success of the program, there are still some barriers that OHCA and other agencies are identifying and working to eliminate. Using focus groups, surveys and on-site observations, Dalton said, they have already determined that locality and transportation are problems for some. Language and varying levels of learning ability also need to be addressed.

"We need multilingual candidates and cultural diversities in this program, and we will work to attract different demographic groups," she said.

The certified nurse's aide program is a joint effort of the Oklahoma Health Care Authority and OSU-OKC, in collaboration with various state agencies. The curriculum is designed to prepare students to complete the state nurse's aide competency examination. The goal of the program is to ease the manpower shortage of Oklahoma's long-term care facilities by attracting candidates and providing quality training. More than half a dozen graduates have already started working at Medicaid long-term care facilities, and others are expected to start in the near future.

There is no cost to qualifying residents of Oklahoma and Logan counties who earn certification and gain employment at a Medicaid long-term care facility for at least 12 months. In addition to the classes being free, participants in the program also receive a free lab coat and three sets of scrubs. Students are required to pass an Oklahoma State Bureau of Investigations background check and nurse aide registry screening before they start training.

For more information about the certified nurse's aide program, call (405) 945-3373.

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Injectables (continued)	
Drug	***Quantity Limits***
PEG-filgrastim (**Neulasta**) *6 mg/0.6 mL injection*	0.6 mL per 21 days (1 pre-filled syringe)
Triamcinolone injection	10 mL per 7 days
Miscellaneous	
Drug	***Quantity Limits***
Gefitinib tablets (**Iressa**) 250 mg tablets	30 tablets per 30 days
Tramadol (**Ultram**) 50 mg tablets; tramadol / acetaminophen (Ultracet) 37.5 / 325 mg tablets	240 tablets per 30 days
Alosetron (**Lotronex**) 0.5 & 1 mg tablets	60 tablets per 30 days
Tegaserod (**Zelnorm**) 2 & 6 mg tablets	60 tablets per 30 days
Lindane shampoo and lotion	60 mL per 7 days

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

This publication is issued by the Oklahoma Health Care Authority in conjunction with the Oklahoma Foundation for Medical Quality as authorized by 63 O.S. Supp. 1997, Section 5013. Eighteen thousand printed pieces have been printed at a cost of .38 cents per copy. Copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries.

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Fall 2005
Provider Update
A publication of the Oklahoma Health Care Authority

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