

OKLAHOMA, WHERE THE WIND COMES SWEEPIN' DOWN THE PLAIN ...

With spring upon us, certain rituals are bound to happen: spring cleaning, buzzing of the bees, renewal of outdoor activities and the annual pollination rituals of the trees, flowers and plants. These days, it seems like it's more than just waving wheat blowing in; for most allergy sufferers, with their inflamed sinuses, there is no smell — sweet or otherwise.

With the change of seasons, allergy sufferers know many of the typical symptoms are on the way that trigger our immune systems to begin fighting foreign bodies. These foreign bodies come in various forms, like tree pollen, mold spores and ragweed. In response to the invaders, the body begins to fight by releasing chemicals (such as histamines), and going into a protective mode (by becoming inflamed) to prevent the alien substances from continuing their journey.

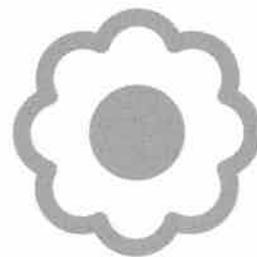
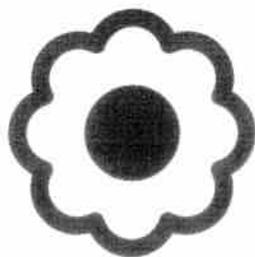
This also activates the other reactions most closely associated with allergies: sneezing, itching eyes and a running nose. While none of these responses is bad in itself — remember, each attempts to protect us — they may continue to progress and lead to infections of the sinuses, upper respiratory system or ears.

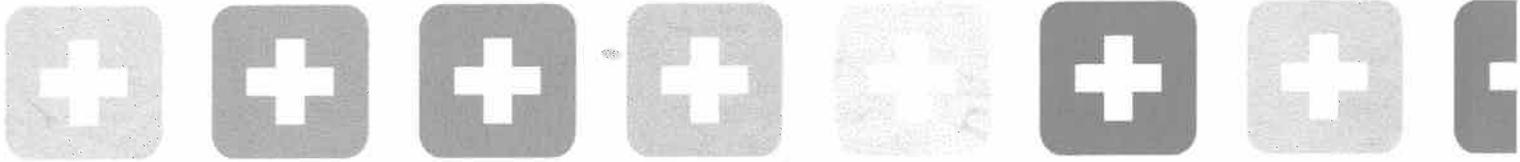
But what if these allergy symptoms to which we are accustomed — the inflamed sinuses, stuffy head and sore throat — are not the only negative physical effects of the seasonal changes? Scientific research suggests there may be more to allergy season than meets the eyes, nose or throat.

Correlations have been found between allergy symptoms and brain function. Research has shown that when the body goes into protective mode, it releases a protein called cytokine in the brain. The release of this particular protein has been identified with fatigue, periods of depressed mood and difficulty concentrating. This connection now is offered as part of the explanation for “springtime blues.”

While the evidence does not show conclusively that allergies lead to depression-like symptoms, it does highlight a relationship that many springtime allergy sufferers previously may not have recognized. At the very least, this information can begin a discussion between primary care providers and members regarding mood swings that may be more closely related to seasonal issues than to situational ones.

**And it all begins with the question,
“So, how do you feel?”**





Developmental/behavioral telephone consultations offer SoonerCare providers resources and evidence-based practices to help maintain a high quality of care among pediatric patients ages 0-6. This phone and email service allows access to the developmental/behavioral pediatricians or nurse practitioners at the Child Study Center on the University of Oklahoma Health Sciences Center campus.

The service is designed to broaden providers' knowledge of developmental/behavioral conditions and to offer guidance on primary care management of children with conditions such as neurodevelopmental disorders, ADHD and autism, as well as learning and/or intellectual disabilities. Consultations can include questions regarding:

- Best practices in developmental/behavioral care;
- Strategies for medication management;
- Recommendations for services and resources; and
- Other issues, as needed.

To access this service, call Peggy Yen at 405-271-5700 or 800-271-2717, or via email at peggy-yen@ouhsc.edu. Office hours are 8:30 a.m. to 5 p.m. Monday through Friday. Calls will be returned within 24 hours for voicemail messages left outside office hours.

PEDIATRIC DEVELOPMENTAL /BEHAVIORAL CONSULTATIONS AVAILABLE FOR SOONERCARE PRIMARY CARE PROVIDERS

MEDICAL NECESSITY IS PARAMOUNT FOR CLAIMS REIMBURSEMENT



As electronic health records (EHR) become a mainstay of medical care, many offer the convenience of prompts to assist with time constraints and assure fair payment. However, evaluation and management (E/M) check-off systems can easily lead into abusive coding and billing. Do not bill according to the number of items checked off. Use an EHR system that includes the flexibility to lead to the correct code and not into trouble. Practitioners must employ sound judgment in using this technology to avoid unnecessary reviews, denials and write-offs.

MEDICALLY REASONABLE AND NECESSARY

The patient's condition is the essential factor in determining medical necessity. The nature of the patient's condition as documented in the medical record, not the diagnosis alone, determines the level of service payable.

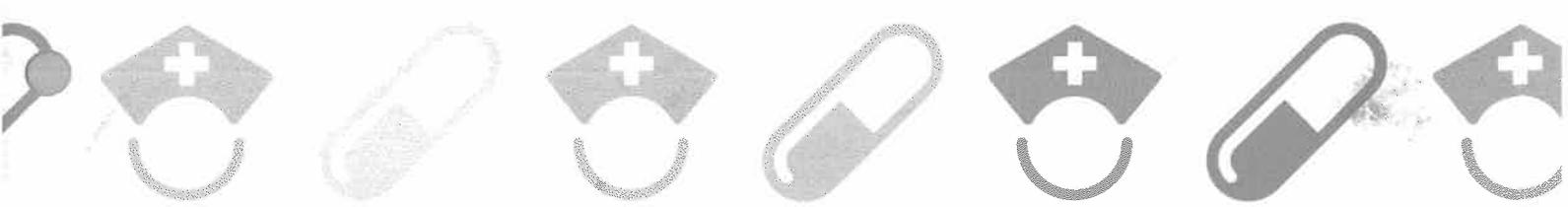
The proper code reflects the history, physical findings and level of decision-making, i.e., the work performed that was medically necessary to treat the patient's specific chief complaint. For billing, coding and reimbursement purposes, medical necessity outweighs the history, the physical exam or medical decision-making. Documenting medical necessity is critical to proper coding.

PHYSICIAN WORK CONSIDERATIONS

The three key components of the physician work part of an E/M encounter are history, physical examination and medical decision-making.

History must be clearly stated and properly recorded; it is essential to substantiate medical decision-making and medical necessity. The amount of documentation required for the history depends on the nature of the patient's presenting problem. History includes:

- **Chief complaint (CC)**, the reason for the visit. Though additional conditions and complaints that lead to physician work are frequently discovered via the process of obtaining the history and performing the examination, it is important to remember to address the chief complaint and document accordingly.
- **History of present illness (HPI)** must describe the patient's symptoms, the evolution of illness and the present status of condition.
- **Review of systems (ROS)**, an inventory consisting of patient answers to practitioner's questions regarding symptoms.
- **Past, family and/or social history (PFSH)** reviews these three aspects as relevant to the complaint or condition and can also include review of the patient's current medications.



Examination should be documented by body area(s) and/or organ system(s). Describe abnormal, unexpected and relevant negative findings. Elaborate on any notations of abnormal findings.

When determining the level of examination, perform and document only those elements for which there is a clear medical indication. For low-level services, documentation need not be lengthy, but must be complete.

Consider the clinical circumstances of the encounter. Services that were already provided at a recent visit and/or services that are not directly required to treating the patient's specific complaint on this visit should not be included for coding or billing purposes.

For example:

- When seeing a 6-month-old child with a classical earache, it is not medically necessary to perform a musculoskeletal exam at that visit.
- If a child just had a complete exam last month, it is not medically necessary to perform another complete exam today for a sore throat.
- If a patient was diagnosed with a corneal infection, had a complete eye exam last visit, no intraocular findings were identified and no new symptoms or signs are present, it is not medically necessary to perform or bill for a comprehensive eye exam - nor is it necessary to perform fundus photography.

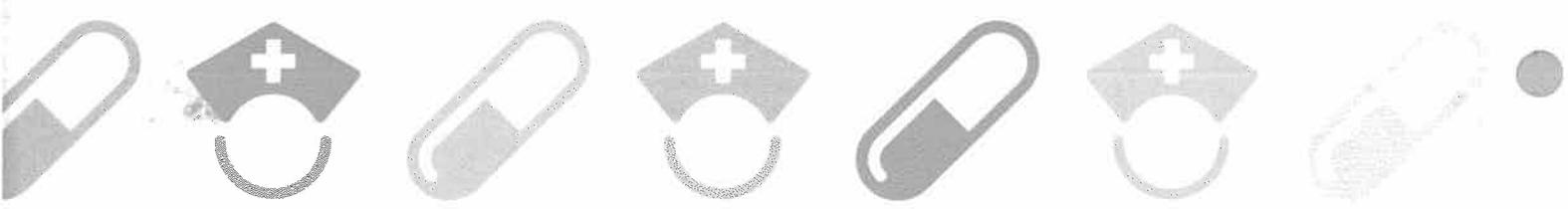
If it is more efficient for office operations and staff training to standardize the patient work-up and documentation, any extra services that are not required to determine the course of treatment at that visit are still **not** billable since they are not medically necessary.

Medical Decision-Making (MDM) is the final key component of most E/M services. Vital information about the patient's condition necessary in determining the medical necessity of the encounter is usually located in the MDM section of the record. Documenting the complexity of medical decision-making adequately is essential for proper claims payment.

The recorded MDM should report the physician's evaluation as the historical and physical information merge into diagnostic impressions and treatment plans. Correspondingly, patient information recorded in the history and physical must support the physician's impressions and management plans.

Coding MDM should not be solely based on the severity or number of presenting problems. Decision-making also encompasses the number of diagnostic tests ordered, performed and reviewed, as well as risks associated with those tests, and the complexity of - and risks associated with - chosen therapeutic options.

Practitioners must ensure that another person can understand their thought process when documenting MDM. Provide explicit information or ready access to such information.



Writing a prescription(s) is not synonymous with prescription drug management. Drug management indicates a significantly higher risk component than writing prescriptions and should be consistent with the risk of the patient's condition.

PITFALLS TO AVOID

- **RECORDING PHYSICAL OBSERVATIONS AS THE REVIEW OF SYSTEMS.**
- **FAILURE TO DOCUMENT THE ASSOCIATION BETWEEN DIAGNOSTIC TESTS AND DIAGNOSES OR POTENTIAL DIAGNOSES.**
- **NOT SUMMARIZING OLD RECORDS OR OTHER OUTSIDE INFORMATION REVIEWED AND INCORPORATED INTO DECISION-MAKING. THE DOCUMENTATION SHOULD INCLUDE THE SOURCE OF THIS INFORMATION.**

Listing established diagnoses or potential diagnoses without additional indication(s). Do record relevant impressions, tentative or confirmed diagnoses, and therapeutic options related to each problem being evaluated or managed at that visit.

- Recording unnecessary information solely to meet requirements of a higher-level service when the nature of the visit dictates a lower-level service to be medically appropriate.
- Including unnecessary material while failing to record clinically pertinent information needed to determine the medical necessity of the service. The service should be coded based on the clinical needs of the patient.
- Lack of consistency, especially when the service is coded using the most favorable sections of different guidelines, causing the overall work and/or medical necessity for the encounter to be overestimated.
- Submitting a medical record containing a perfectly complete history and examination, without an equally complex MDM. Without adequate record of physician impressions and planned diagnostic/therapeutic

intervention, the encounter might be rendered of no clinical benefit at all and not payable at any level.

In summary, coding based on documentation absent underlying medical necessity is always inappropriate. Physicians should bill only for those items that are medically necessary or they may find their practice subject to significant oversight and recoupment. Conversely, medical necessity alone, in the absence of documented physician work, is not a sufficient basis for payment. This is true of each component of the medical record for an E/M service.

Though an E/M service may code to a high level based on the documentation of key component work, it is inappropriate to request payment when the patient's effective management does not require the code's work. Allow the level of service to dictate the volume of documentation for each section. To ensure fewer claims denials and appropriate care for patients, utilize medical necessity to guide the care provided, document the care accurately and code services based on that documentation. Additional helpful information is available through Medicare's website, including these links:

Documentation Guidelines for Evaluation and Management <https://www.cms.gov/Manuals/10M/itemdetail.asp?itemID=CMS018912>

Services Claims Processing Manual http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp

SOONERPLAN MOVES TO THE STATE PLAN

After a six-year family planning demonstration period, the SoonerPlan program transitions from a waiver to the State Plan, effective June 1. This is a seamless transition for providers and members. Under the State Plan, the SoonerPlan program has increased opportunities for enhancement of family planning services and care.

SoonerPlan provides family planning services and contraceptive products to men and women who qualify. SoonerPlan providers have served more than 105,000 members since inception of the program in 2005. According to member satisfaction surveys, SoonerPlan members continue to give a "highly satisfied" response rate for the program, as well as for the care and education offered by SoonerPlan providers. The SoonerPlan benefit package includes:

- Birth control information and supplies;
- Laboratory tests related to family planning services, including pregnancy tests, Pap smears and screenings for sexually transmitted infections; and
- Tubal ligations and vasectomies for those ages 21 and older.

Qualified SoonerPlan members will have an expanded birth control formulary under the State Plan, in addition to the same family planning benefits previously offered. SoonerPlan members also will receive other related services, such as Gardasil, in their benefit package under the State Plan.

To qualify for the SoonerPlan program, individuals must have a household income at or less than 185 percent of the federal poverty level guidelines. Individuals with insurance are eligible to apply.

For questions regarding SoonerPlan or the transition, call the Provider Helpline at 800-522-0114 or 405-522-6205.



*provider + update
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NEW TDAP IMMUNIZATION REQUIREMENT IN EFFECT FOR FALL SEMESTER

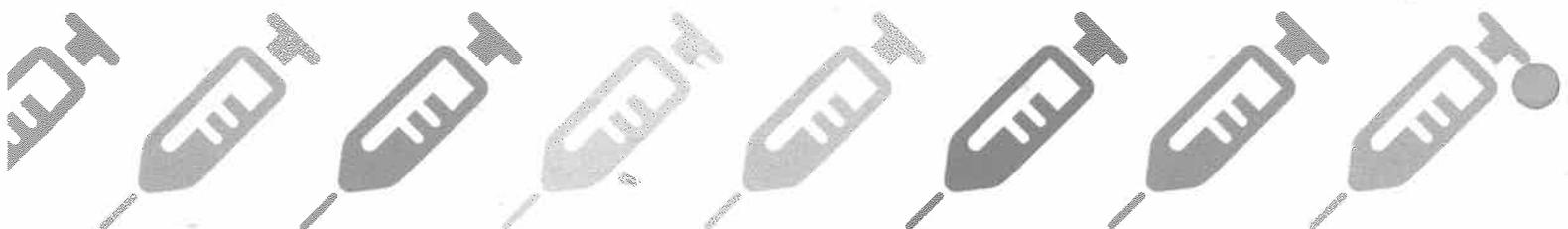
Beginning with the 2011-12 school year, the Tdap (tetanus, diphtheria, acellular pertussis) vaccine will be required for students prior to entering the seventh grade. Tdap is a booster to the five childhood DTaP immunizations, and this new regulation is being put into effect to help fight the spread of whooping cough in Oklahoma schools and communities.

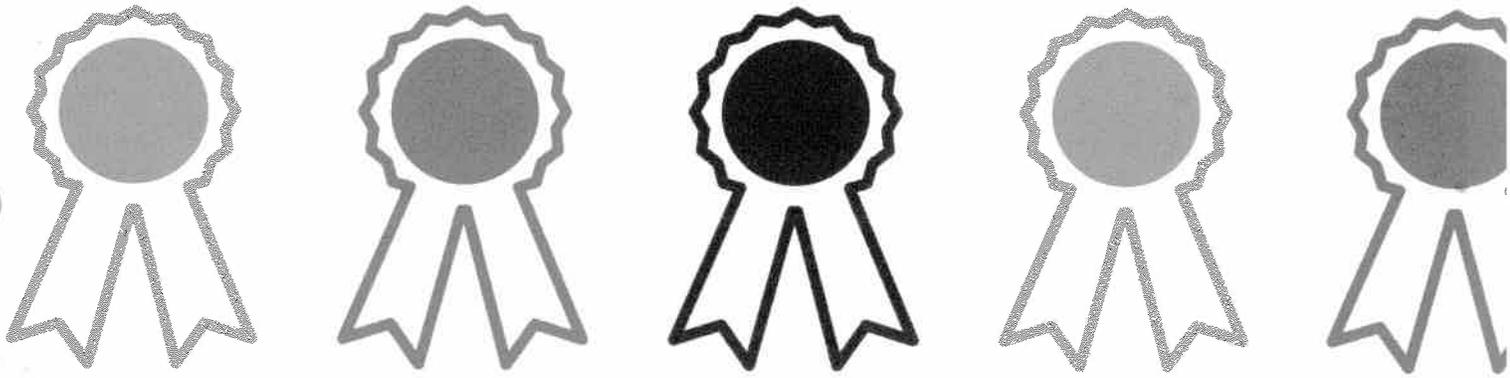
The Tdap requirement will be expanded incrementally over a six-year period, from seventh grade this first year to seventh through 12th grades by the sixth year of implementation (2016-17), as illustrated by this table:

School Year	Grades Affected by Tdap Requirement
2011-12	7
2012-13	7-8
2013-14	7-9
2014-15	7-10
2015-16	7-11
2016-17	7-12

Oklahoma State Department of Health officials urge parents of sixth graders to seek vaccinations for their children now, rather than waiting for the July and August back-to-school rush.

No grace period is allowed for students to comply with this requirement, with the exception of military children transferring from another state. Military children may be allowed up to 30 days from the date of enrollment to obtain state-required immunizations. All other students must receive the vaccine and present an immunization record before entering the seventh grade.





OHCA TEAM PROJECTS RECEIVE COMMENDATIONS FOR EXCELLENCE

Five projects of the Oklahoma Health Care Authority (OHCA) were awarded the Governor's Commendation for Excellence at Quality Oklahoma Team Day 2011, held May 5 at the state Capitol.

Quality Oklahoma Team Day is an annual event hosted by the Office of Personnel Management in conjunction with Public Service Recognition Week. It is an opportunity for state agencies to share the outcomes of successful projects accomplished by agency work teams, and for those projects to be seen by state agency officials, members of the state Legislature and the public. Team Day seeks to recognize employee innovation, collaboration and accomplishment.

This year, a total of 55 teams from 10 state agencies participated in the event.

OHCA had two teams with booth-only exhibits, in addition to the 11 teams presenting projects for consideration of awards. The presenting projects (with award winners appearing in bold) were:

- Behavioral Health Consolidated Claims Processing and Outcomes Data
- Electronic Provider Notifications
- Focus on Excellence

- **Measuring Success: SoonerCare's Payment Accuracy Project**
- **OHCA Online Enrollment**
- Online: Proposed Rule Change
- **Practice Facilitation: Strengthening Primary Care for Chronic Illness in Oklahoma Through the SoonerCare Health Management Program**
- Reducing Psychiatric Residential Treatment Expenditures
- **Statewide Care Management Oversight Project**
- **SoonerCare Choice: Oklahoma's Patient-Centered Medical Home Program**
- SoonerCare Member Advisory Task Force
- SoonerEnroll: Partnering for a Healthy Oklahoma
- SoonerQuit Prenatal Initiative

OHCA also continued its tradition of winning specialty awards. This year, OHCA Online Enrollment received the Motivating the Masses Award, an honor given to the team that demonstrates how it was able to facilitate collaboration across many agencies to reach project goals.

Congratulations to the award-winning teams, and kudos to all the teams for their partnerships and hard work.

PRIOR AUTHORIZATION NOW REQUIRED TO PRESCRIBE SUBOXONE, SUBUTEX



Suboxone (buprenorphine HCl/naloxone HCl dihydrate) and Subutex (buprenorphine HCl) are Schedule III narcotics approved by the Food and Drug Administration (FDA) in 2002 for the treatment of opioid dependence. These drugs are the first medications approved for office-based treatment of opioid dependence under the Drug Addiction Treatment Act of 2000 (DATA).

Before this law was passed, treatment of narcotic dependence was provided only at clinics that were specially registered, and it was illegal for other doctors to prescribe narcotic drugs for treating opioid dependence. Under DATA, Schedule III, IV and V medications can be prescribed for opiate-addicted patients who are treated by specially qualified doctors in their private offices. The intent of these changes was to make treatment more accessible to patients addicted to opioids for whom other treatment options were not available.

Although these medications are intended to treat opioid addiction, they also pose a risk of dependence. Due to the addition of naloxone, Suboxone may produce severe withdrawal symptoms if misused parenterally by patients dependent on heroin, morphine or methadone. It also may cause withdrawal symptoms in such patients if administered before the agonist effects of the opioid have subsided. Chronic administration of both Suboxone and Subutex can cause withdrawal symptoms upon abrupt discontinuation or rapid taper. Deaths have been reported when using the medications inappropriately, such as administering Suboxone or Subutex intravenously (usually along with benzodiazepines), or sublingual administration concomitantly with alcohol, sedatives or other opioids.

Drug abuse is on the rise with these agents; some patients do not intentionally abuse the drugs, but end up self-medicating because they don't have access to addiction treatment. They may be "doctor-shopping" and using other methods of diversion in order to obtain Suboxone and Subutex. In order to reduce these instances, a series of recommendations has been put in place by the Substance Abuse and Mental Health Services Administration. The recommendations include easier access to treatment for opioid addiction, as the lack of available treatment is a significant contributor to the diversion of the drug. The recommendations also include enhanced physician training in order to ensure appropriate dispensing and management of Suboxone and Subutex.

Although both agents originally were designed to meet FDA requirements for a more diversion-proof drug, they are commonly abused due to the intense sensation of euphoria they can produce. Because of this potential for abuse, the FDA moved the medications from Schedule V to Schedule III in 2002, which increased the penalties for obtaining the medications illegally or abusing them. Unfortunately, recent data indicates that abuse remains a problem.

Large percentages of populations using Suboxone and Subutex have admitted to abusing them by injection, as well as in combination with a benzodiazepine. Statistics reported by the Drug Abuse Warning Network claim there were an estimated 14,266 emergency room visits associated with the misuse of Suboxone and Subutex in 2009. This number is more than three times the 2006 estimate of 4,440 emergency room visits in the same category. The Drug Enforcement Administration (DEA) reports that federal, state and local laboratories identified 7,786 drug seizures due to Suboxone and Subutex abuse in 2010, which is six times the reported number of 1,291 in 2006.

Due to the increase in diversion of these products, Medicaid agencies in several states, including the Oklahoma Health Care Authority (OHCA), have implemented prior-authorization requirements for coverage. OHCA has established the following criteria for coverage of Suboxone and Subutex:

- Products must be prescribed by a licensed physician who qualifies for a waiver under the Drug Addiction Treatment Act (DATA), has notified the Center for Substance Abuse Treatment of the intention to treat addiction patients, and has been assigned a DEA number.
- Diagnosis of opiate abuse/dependence is required.
- Combination with benzodiazepines, hypnotics, and opioids (including tramadol) is not covered.
- Approval will be for 90 days to allow for concurrent medication monitoring.
- The following limitations apply:
 - Suboxone 2 mg/0.5 mg and 8 mg/2 mg tablets and film carry a quantity limit of 90 per 30 days.
 - Subutex 2 mg tablets and 8 mg tablets will be approved only if the member is pregnant (the product may be used for the duration of the pregnancy only), or has a documented serious allergy or adverse reaction to naloxone.



In order for physicians to prescribe Suboxone and Subutex, they must receive waivers from the special registration requirements in the Controlled Substances Act for the provision of medication-assisted opioid therapy. To receive this waiver, a physician must notify the Center for Substance Abuse Treatment of his or her intent to begin dispensing or prescribing this treatment before the initial dispensing or prescribing of therapy with Suboxone or Subutex. The waiver notification section at http://buprenorphine.samhsa.gov/waiver_qualifications.html provides information on how to obtain and submit a Notification of Intent form, which contains all the data items necessary to expedite the timely processing.

Along with the waiver, physicians also must obtain a special identification number from the DEA to prescribe Suboxone and Subutex. The regulations set forth from the DEA require this ID number to be included on all Suboxone or Subutex prescriptions for opioid addiction therapy, along with the physician's regular DEA registration number. One or more of the following criteria must be met in order for a physician to qualify:

- The physician holds a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties.
- The physician holds an addiction certification from the American Society of Addiction Medicine.
- The physician holds a subspecialty board certification in addiction medicine from the American Osteopathic Association.
- The physician has, with respect to the treatment and management of opioid-addicted patients, completed not less than eight hours of training (through classroom situations, seminars at professional society meetings, electronic communications or otherwise) that is provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association or any other organization that the secretary determines is appropriate for purposes of this subclause.

- The physician has participated as an investigator in one or more clinical trials leading to the approval of a narcotic drug in Schedule III, IV or V for maintenance or detoxification treatment, as demonstrated by a statement submitted to the secretary by the sponsor of such an approved drug.
- The physician has such other training or experience as the state medical licensing board (of the state in which the physician will provide maintenance or detoxification treatment) considers to demonstrate his or her ability to treat and manage opioid-addicted patients.
- The physician has such other training or experience as the secretary considers to demonstrate his or her ability to treat and manage opioid-addicted patients. Any criteria of the secretary under this subclause shall be established by regulation. Any such criteria are effective only for three years after the date on which the criteria are enacted, but may be extended for such additional discrete three-year periods as the secretary considers appropriate for purposes of this subclause. Such an extension of criteria may be effectuated only through a statement published in the Federal Register by the secretary during the 30-day period preceding the end of the three-year period involved.

For more information regarding DATA or for additional instruction on the physician qualification process, visit <http://buprenorphine.samhsa.gov/index.html>.

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Please submit any questions or comments to Carter Kimble the Oklahoma Health Care Authority's Public Information Office at (405) 522-7510.

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