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Electronic Data Systems (EDS) Takes Over as New Fiscal Agent

Electronic Data Systems will take over as the fiscal agent and claims processor for Oklahoma Medicaid claims on December 12. EDS has more than 30 years experience in the public health care industry and has constructed one of the most advanced Medicaid Management Information Systems (MMIS) in the nation. With the new MMIS, OHCA can now offer providers several new services, including more efficient options to obtain eligibility and prior authorization information before providing a service. In addition, claim submission can now be done with the speed of the Internet.

Lynn Puckett, analyst/planning specialist for OHCA, said one of the most exciting services with the change to EDS is the Electronic Data Interchange (EDI), which gives providers the ability to submit claims via the Internet. Information can be relayed in real time, reducing human errors. Submitting claims electronically will also save providers money in the long run.

"There will be less cost to the providers and it will save turnaround time," Puckett said. "Many requests can be completed on the Web in real time."

Before EDS, providers could only find out if a claim was going to be approved after the billing cycle was complete. Now, in most cases providers can know immediately if a claim is going to be approved or denied. If it is going to be denied, they can access the claim, correct errors and resubmit immediately.

Virginia Benson, provider relations manager for EDS, spoke to a large group of providers at Oklahoma City Community College on November 1. One hundred eight training seminars were held to prepare Medicaid providers for the switch to the new fiscal agent.

Providers with Internet capabilities will also be receiving an electronic remittance advice (RA). The RAs will be in a standard file format that most programs will recognize, Puckett said. Providers will be able to program their computers to accept the file, which will save data processing time because each claim will not

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The Leapfrog Group Focuses on Reducing Medical Errors

The Leapfrog Group is a non-profit coalition of more than 120 public and private organizations that provide health care benefits. They are asking hospitals around the country to voluntarily complete a survey on three inpatient safety practices.

The Leapfrog Group was formed in 2000 and is a growing consortium of Fortune 500 companies. The organization has made a commitment to improve patient safety within hospitals by basing health care purchasing decisions on principles that encourage stringent patient safety measures. They are educating employees and families to make informed health care choices and rewarding hospitals that implement significant safety improvements.

Approximately 98,000 people die each year in America's hospitals as

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The Leapfrog Group (continued from page 1)

a result of preventable medical mistakes, according to a 1999 report from the Institute of Medicine. While death is the most tragic outcome, medical mistakes also lead to permanent disability, extended hospital stays, longer recoveries and significant additional costs.

The Leapfrog Group has initially identified three hospital safety measures that will be the focus for health care provider performance comparisons, recognition and rewards. Based on independent scientific evidence, the initial set of safety measures includes: computerized physician order entry, evidence-based hospital referral, and intensive care unit staffing by physicians trained in critical care medicine.

- **Computer Physician Order Entry (CPOE):** With CPOE systems, physicians enter medication orders through a computer, which is linked to prescribing error prevention software. CPOE has been shown to reduce serious prescribing errors in hospitals by more than 50 percent. In addition to contributing to more than 7,000 deaths annually, medication errors also result in tremendous financial costs, including an average of $2,000 to the patient's hospitalization, which translates to $2 billion per year nationwide in hospital costs alone, according to *JAMA* articles cited by The Leapfrog Group.

- **Evidence-Based Hospital Referral:** By referring patients needing certain complex medical procedures to hospitals offering the best survival odds based on scientifically valid criteria – such as the number of times a hospital performs these procedures each year – research indicates that a patient's risk of dying could be reduced by more than 30 percent. Procedures included in the survey for evidence-based hospital referral include: coronary artery bypass graft, coronary angioplasty, abdominal aortic aneurysm, carotid endarterectomy, esophageal cancer surgery, deliveries less than 1500 grams or less than 32 weeks of gestation and delivery with congenital anomalies.

- **ICU Physician Staffing:** Staffing ICUs with physicians who have credentials in critical care medicine has been shown to reduce the risk of patients dying in the ICU by more than 10 percent. The Leapfrog Group supports the use of "intensivists," or physicians specifically trained in managing critically ill patients in the ICU, as well as "closed system" ICUs where critical patients are "cared for exclusively by critical care specialists or teams."

Dr. J. Paul Keenan, associate medical director with the Oklahoma Health Care Authority, is encouraging physicians, for the benefit of their patients, to help and actively encourage the administration of their hospitals through the appropriate committees and/or the medical director to participate in the survey.

"The survey would be an excellent tool to stimulate quality of care discussions and education among the hospital staff," Keenan said. "It could be used to promote to health care purchasers and patients the commitment made by the hospital to quality care."

The Leapfrog Group chose these measures because scientific evidence indicates that each has significant potential to save lives by affecting factors that influence preventable medical mistakes or bad outcomes. The Leapfrog Group is currently targeting hospitals in the following regions: Atlanta, Ga.; California; East Tennessee; Minnesota; Seattle/Tacoma/Everett, Wash.; and St. Louis, Mo. Hospitals in all parts of the country, however, are encouraged to fill out the survey. The Leapfrog Group intends to expand its outreach efforts across the rest of the nation in the near future and will also expand its focus to include other aspects of health care such as doctor's office visits.

"Reducing medical errors will be accomplished by focusing on systems solutions instead of finding blame," Keenan said. "That is why providers should encourage participation and assist in the patient safety hospital survey. In addition, they should be prepared to use the information gained to work with the hospital and other providers to create a plan of action. OHCA strongly supports all efforts by providers to improve the safety and quality of care provided in medical institutions caring for Oklahomans."

Leapfrog Group test hospitals estimate that it will take one to three days to gather the information necessary for the survey, and approximately 30 minutes to complete. Answers to frequently asked questions about the Hospital Patient Safety Survey can be found at the Leapfrog website, including information about how the survey was developed, who should complete it and what rules apply to multi-hospital systems and surgical teams that practice in more than one facility.

For more information for hospitals or consumers, consult The Leapfrog Group website at www.leapfroggroup.org.

New Client ID Cards Take Effect Dec. 19

New WHITE Medicaid I.D. cards and new client I.D. numbers will go into effect on Thursday, December 19. The current blue cards will not function by swiping through a POS terminal after December 19. However, the old client I.D. numbers can be used with a POS until December 29 by typing in the numbers. There will be three methods available to check Medicaid eligibility: POS terminal (swipe card), Internet and telephone. The NEW nine-digit Medicaid client I.D. number will be on the white I.D. card eliminating the need to track old Medicaid I.D. numbers.

Providers must have the following information available to check eligibility:

Either 1) Client Medicaid I.D. OR
2) Client Social Security number AND date of birth.

1) POS Terminal
   a. Swipe the card through the terminal OR
   b. Type the Client Medicaid I.D. on the terminal keys OR
   c. Type the Client Social Security number AND date of birth on the terminal keys
2) Internet (Beginning December 26)
   a. Log onto the providers secure OHCA web page – using the NEW Provider I.D. and PIN number
   b. Click on the Eligibility Tab
   c. Enter Client Medicaid I.D. OR the Client Social Security number AND date of birth
3) Telephone: 405-840-0650 (OKC Metro) OR 800-767-3949 (All new features including speech recognition begin December 31!)
   a. Have ready the NEW Provider I.D. and Location Code (an alpha character) for identification
   b. Have ready either:
      1. Client Medicaid I.D. OR
      2. Client Social Security number AND date of birth
   c. Follow the prompts for either speech recognition or the keypad entry

Note: Although the new phone system is much easier to use, it is not recommended to use cell phones, speaker phones and headphones with a voice activated system.

Holiday Blues or Seasonal Affective Disorder?

The holiday season is not all brightly-colored wrapping paper with cheery attitudes to match. During this time of joy many people are overcome with depression brought on by the holiday season. For many, the holidays are a time of self-evaluation; loneliness when not able to spend the time with family or friends, reflection on past failures and anxiety about an uncertain future; and reminiscence of lost loved ones, whether by death or broken relationships.

Other than depression, people can develop stress-related responses, such as: headaches, excessive drinking, over-eating and difficulty sleeping. Holiday stress usually comes from the added responsibilities and activities, fatigue and financial constraints experienced by most this time of year. Stress that continues unchecked can and does develop into more serious physical, medical and psychological problems.

Other individuals may experience "post-holiday letdown" after January 1. Post holiday letdown results from excessively high expectations, disappointments and from the fatigue and stress of the holidays.

When a physician believes his patient may be suffering from holiday depression, he or she should refer them to a qualified mental health professional to be assessed formally. While some patients may be experiencing normal stress and depressive symptoms and will be fine, there are others who may need a combination of medication and psychotherapy to get through this period. Still others may be chronically depressed and/or anxious and need ongoing professional services.

Seasonal Affective Disorder (SAD)

Physicians and mental health providers should also watch for seasonal affective disorder. Many with what may be labeled as a holiday depression might actually have fall-onset SAD, also known as "winter depression." It includes major depressive episodes that begin in the late fall to early winter months and subside during the spring and summer months. Atypical signs and symptoms of depression predominate in cases of winter depression and may include the following: increased rather than decreased sleep; increased rather than decreased appetite; carbohydrate cravings; marked increase in weight, irritability; interpersonal difficulties;

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Preventing Preterm Low Birth Weight

by Belinda Rogers, OICA

The overall health status in the United States can be measured by several key indicators such as infant mortality and low birth weight. While much has been gained in the fight against infant mortality, the nation's infant mortality rate (IMR) of eight deaths per 1,000 births ranks the United States 26th in the world[1].

Although infant mortality rates have been decreasing, low birth weight rates have been increasing on a national and local level. Preterm low birth weight is defined as infants born at less than 37 weeks gestation and weighing less than 5.5 pounds. The lower the birth weight, the higher the risk of an infant having health complications. A low birth weight baby is 23 times more likely to die before his or her first birthday and is 25 times more likely to have brain damage and birth defects[1]. The fact is when babies are born too small they begin too far behind. Some can catch up, but it costs them and their family tremendous time and energy, taxing them emotionally and financially.

A key goal in the movement toward the prevention of preterm low birth weight is to develop new conceptual frameworks for research and intervention. Promising new research has begun to demonstrate links between preterm low birth weight and bacterial vaginosis, stress and periodontal disease.

Bacterial Vaginosis

In recent years, researchers have identified bacterial vaginosis (BV) as a possible cause of preterm delivery and associated low birth weight. Women are known to be more susceptible to contacting bacterial vaginosis if they douche regularly or if they are under a great deal of stress[2]. Douching kills the healthy bacteria in the vagina and allows harmful bacteria to grow. These unhealthy bacteria may cause premature rupture of membranes, initiating early labor. According to a recent study, 66.5 percent of African American women douche in comparison to 32 percent of Caucasian women[3]. The study also found that African American women are approximately two to three times more likely than Caucasian women to have bacterial vaginosis.

Stress

Increasing evidence shows that the human immune system is influenced by psychosocial factors. Stress and its chemical changes in the body can depress the immune system. Maternal behavioral responses to stress can negatively influence fetal health. Stress, as a psychosocial factor has been significantly associated with preterm low birth weight[4]. The pressures of low economic status and domestic violence can place individuals at high risk for stress related conditions. A national family violence survey estimated that pregnant women had a 61 percent greater risk of being subjected to "abusive violence" than their nonpregnant counterparts[5].

Periodontal Disease

Researchers have also been studying the effects of periodontal disease on preterm low birth weight. Some believe that in high concentrations, bacteria in the gums may release enzymes that cause premature rupture of uterine membranes and the onset of early labor. A recent study stated that periodontal disease may account for as much as 18 percent of low birth weight cases[6]. This study also found that women who had periodontal disease were seven times more likely to give birth to preterm low birth weight babies than women who did not have the disease.

Since the factors linked to low birth weight and preterm delivery are varied, the actions taken to prevent preterm low birth weight must also be varied. While some efforts may rely on changes in the current health policy, many simply require health providers, advocates and consumers to be aware of effective prevention measures. Here are some strategies health care providers can put into practice.

Strategies for Providers: Act on new findings and improve what is already known.

- Start early and educate young women about reproductive health issues.
- Educate clients about the health risks associated with douching.
- Continue or initiate regular education about bacterial vaginosis.
- Encourage pregnant clients and women of childbearing age to get regular dental exams to help prevent, detect and/or treat periodontal disease.
- Be aware of violence issues, especially those that occur during pregnancy, and make referrals to appropriate intervention programs.
- Provide access to comprehensive prenatal care, such as smoking cessation programs, stress counseling, nutrition education, etc.

The Healthy Beginnings Campaign, a project of the Oklahoma Institute for Child Advocacy, funded by a grant from the March of

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New Formats Required for Pharmacy Claims

OHCA Point-of-Sale (POS) currently accepts electronic claims in the NCPDP versions 5.1, 5.0 and 3.2 formats or on paper with our current fiscal agent, Unisys. Beginning Dec. 19, 2002, OHCA will only accept POS claims in NCPDP version 5.1 through our new fiscal agent, EDS. The decision to migrate the new system to the 5.1 format was based largely on the requirement of the Health Insurance Portability and Accountability Act (HIPAA). There will not be any extensions granted to accept electronic pharmacy claims submitted using the lower versions of the format.

NCPDP version 5.1 allows the pharmacists to enter compounds with up to 25 ingredients. Prospective Drug Utilization Review (ProDUR) functions are enhanced in this version of the NCPDP format, including interactive response to ProDUR alerts, variable levels of alert notification, and more detailed information for pharmacists. **All versions lower than 5.1 will be rejected after Dec. 17, 2002.** For those providers who will not be able to process POS claims using NCPDP version 5.1 or over the Internet, EDS will continue to accept paper claim submissions. A new paper form for claims will be required. The paper claim form can be obtained from the OHCA website or from the Provider Billing and Procedure Manual. The manual is available at the OHCA website at www.ohca.state.ok.us.

In addition, pharmacies that are contracted as medical suppliers will be able to process DME claims over the Internet. This includes diabetic testing supplies and home health care items.

A survey of software vendors serving Oklahoma pharmacies revealed that all vendors will have the version 5.1 software available well before the December start date. As other third party payers begin to require version 5.1, it will be imperative that pharmacies upgrade their software to comply with HIPAA and with the requirements of each payer. Please contact your software vendor if you have questions about the capability of your system.

All versions lower than 5.1 will be rejected after Dec. 17, 2002.

To facilitate the transition from Unisys to EDS, the POS system will go down at 6:00 p.m. Dec. 17, 2002 and come back up on Dec. 19, 2002. No claims will be processed on Dec. 18, 2002. Eligibility verification will be available through the REVS systems or by calling the OU College of Pharmacy (COP) help desk. Providers may call the REVS system locally at 405-840-0650 or toll-free in Oklahoma and surrounding states at 1-800-767-3949. The COP can also be called locally at 405-271-6349 or toll-free in Oklahoma and surrounding states at 1-800-831-8921.

Preventing Preterm Low Birth Weight (continued from page 4)

Dimes, is working to connect pregnant women to available health resources and helping to educate providers and consumers on the importance of early prenatal care. For more information about the campaign or to schedule an in-service training for staff contact Belinda Rogers at 405-236-5437 ext. 107 or brogers@oica.org.

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Customer Service: Keeping You Informed

Q Currently, I bill electronically to Unisys. How do I make sure I can bill electronically to EDS?

A Providers, billing companies and clearing houses must complete an EDI application, available through the OHCA website at www.ohca.state.ok.us. Once the application has been completed and sent in, the billing entity must test with EDS to be authorized to submit X12 transactions. Please direct further questions to the EDS help desk at (405) 416-6801.

Q Where can I obtain the new forms to use with the new MMIS?

A The forms are available from the OHCA website or from the Provider Billing and Procedure Manual. The manual is available at the OHCA website at www.ohca.state.ok.us.

Q I bill nursing home claims. Will I still only be able to submit claims once a month?

A No, the new Medicaid Management Information System through EDS makes it possible for nursing homes to submit claims as often as weekly. Long-term care providers will start using form UB-92 for billing services on and after Dec. 12, 2002. Billing instructions can be obtained at the OHCA website and from the Provider Billing and Procedure manual (also available on the OHCA website, www.ohca.state.ok.us).

Q I provide transportation for clients who are Medicaid eligible. How does the fiscal agent change and HIPAA compliance affect me?

A Transportation providers will file a HCFA 1500 form beginning December 12. Billing instructions can be obtained at the OHCA website and from the Provider Billing and Procedure manual (also available on the OHCA website, www.ohca.state.ok.us).

Q I understand all active providers will be receiving a new provider number. When will I receive this number?

A The letter containing the new provider number will be mailed out at the end of November.

Electronic Data Systems (EDS) Takes Over as New Fiscal Agent (continued from page 1)

have to be entered individually. In addition to saving time, the new process will enable providers to save money on forms, office supplies, postage, document management and storage fees. Risk of lost claims and human errors with the Internet system is minimized. EDS will continue sending paper RAs to providers who do not have Internet capabilities.

The new Internet service will also allow OHCA to communicate global messages that will appear when providers log onto the site. Messages such as reminders to renew Medicaid contracts that used to be attached to the RAs will now be sent electronically whenever possible.

"We're hoping this will get our information to our providers faster and more efficiently," Puckett said. The Web is also available 24 hours a day, seven days a week. Starting December 26, providers will have access to EDS data including global messages; eligibility information and responses; prior authorization inquiries and submissions; claim submissions and corrections; payment summaries; online adjustments; and RAs.

To access the secure site from OHCA's main web page, go to www.ohca.state.ok.us and click on "Provider" at the top menu bar, then choose "Provider Services" from the drop-down menu.

Holiday Blues or Seasonal Affective Disorder? (continued from page 3)

and a leaden paralysis (heavy feeling in the arms or legs). Other symptoms include the usual features of depression: decreased sexual appetite, lethargy, hopelessness, suicidal thoughts, lack of interest in normal activities and social withdrawal. SAD is often misdiagnosed as a medical problem such as, hypothyroidism, hypoglycemia, infectious mononucleosis or other viral infections.

Young adults and women seem to have the highest risk for the disorder, but it can affect anyone (these statistics may be skewed since men and older adults do not seek help as often). In fact, an estimated 25 percent of the population suffers from mild winter SAD, and 4 to 6 percent suffer from a more severe form of the disorder. Only 6 percent of patients with SAD seen at the National Institute of Mental Health (NIMH) have required hospitalization, and very few have been treated with electro-convulsive therapy. Milder versions of SAD have been reported in children and adolescents. Many people with SAD report at least one close relative with a psychiatric condition, most frequently a severe depressive disorder (55 percent) or alcohol abuse (34 percent). Patients living at different latitudes note that their winter depressions are longer and more profound the farther north they live. Patients with SAD also report that their depression worsens whenever the weather is overcast at any time of the year and/or their indoor lighting is decreased.

SAD isn't totally understood, but has been linked to melatonin, the sleep-related hormone secreted by the pineal gland in the brain. This hormone is believed to cause the symptoms of depression and is produced at increased levels in the dark, and when the days are shorter and darker. As seasons change, circadian rhythms, or our biological internal clocks, change as well in response to changes in sunlight patterns. SAD symptoms are most pronounced in January and February when the days are shortest.

Treatment for SAD doesn't need to wait for the longer sunshine of spring and summer. For those with mild SAD symptoms, health care providers might recommend time outdoors during the day, or arranging homes and workplaces so that they will receive more sunlight. One study found that an hour walk in the winter sunlight was as effective as two-and-a- half-hours under bright, artificial light.

Many with what may be labeled as a holiday depression might actually have fall-onset SAD, also known as "winter depression."

For more severe symptoms, a light treatment called phototherapy might help. Phototherapy has been shown to suppress the brain's secretion of melatonin. Although research hasn't proven that treatment to have an antidepressant effect, it has helped many people.

The device most often used today is a light box that emits very bright light through a filter, usually 10,000 lux directed toward the patient at a downward slant. Patients may sit in front of the light box for a few minutes every day while they work or do other activities. Although some patients show immediate improvement after light therapy, most require two to four days to see antidepressant results. Others may require weeks for symptoms of depression to disappear. Light box prices usually range from $200 to $600. If phototherapy has no effect, an antidepressant medication may help reduce or eliminate SAD symptoms.

The most prudent response for anyone experiencing stress or depressive symptoms is to seek out a mental health professional in order to determine the best course of treatment. Mental health professionals can be found in your local phone book, on the Internet through professional organizations and by word of mouth from friends and family. The best preventative for holiday stress and depression is to pay attention to your body, get plenty of rest, eat nutritious and balanced meals, decrease any extraneous activities, develop holiday rituals that fit within your belief system and are comforting, and to spend time with those you feel most comfortable with. And lastly, the holidays are a time of giving and thinking of those who are less fortunate than you. Giving to those in need does a lot of good for one's heart, body and soul.

The preceding article was adapted from information from the National Mental Health Association, www.nmha.org, the National Association for Mental Illness, www.nami.org and the Behavioral Health Department of the Oklahoma Health Care Authority.

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