

PROVIDER INSIDER



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DIABETES UPDATE
Improvement in HEDIS results

MEDICATION MANAGEMENT
FOR MEMBERS WITH ASTHMA

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MEET US ON THE INTERNET!

We've updated our website westernhealth.com by adding more helpful information for members and providers.

To download a pdf version of the Provider Insider, please visit westernhealth.com/providers/newsletters.cfm



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QUARTERLY PROVIDER INSIDER

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HPDM 10/2011

FALL 2011

PHARMACY & THERAPEUTICS

COMMITTEE UPDATE

WHA'S P&T COMMITTEE MEETS MONTHLY TO DISCUSS PHARMACY RELATED TOPICS AND DISTRIBUTE INFORMATION THAT IS RELEVANT TO HEALTHCARE PROVIDERS.

LOW MOLECULAR WEIGHT HEPARINS

The P&T Committee reviewed the prior authorization criteria for low molecular weight heparins. The current clinical recommendations are for 14 days of therapy following both hip and knee surgery. Therefore, the Committee voted to allow up to a 14 day supply to be filled without a prior authorization (PA) request. A PA is required for longer duration use of these drugs.

NEW GENERICS

The following new generic medications are now available.

- carbamazepine ER (generic *Carbatrol*®)
- latanoprost (generic *Xalatan*®)
- letrozole (generic *Femara*®)
- levofloxacin (generic *Levaquin*®)
- methylphenidate ER (generic *Concerta*®)

The generic dispensing rate for WHA Book of Business has reached 78%. The physicians at Woodland Health Care are exceeding 80%. Generics save patients on copayments and the Plan and Medical Groups on total drug cost.

SUBOXONE

Suboxone (buprenorphine/naloxone) is FDA approved for use in narcotic addiction programs for stabilization and medically supervised discontinuation. It is not approved by the FDA for treatment of pain. Therefore, WHA does not cover the drug for this indication.

Physicians must have special training to prescribe *Suboxone*. A prior authorization is required for coverage and is approvable for a period of one year for stabilization and detoxification. However, Suboxone therapy for chronic maintenance is not a covered benefit for WHA members.



NEW TECHNOLOGY

ASSESSMENT

WHILE SOME NEW TECHNOLOGIES MAY PROVE TO BE ADVANTAGEOUS FOR OUR MEMBERS, OTHERS MAY ACTUALLY CAUSE HARM. THEREFORE, HEALTH CARE SERVICES THAT INVOLVE NEW TECHNOLOGIES OR CLINICAL TRIALS REQUIRE PRIOR AUTHORIZATION (PA) BY WHA TO ENSURE SAFETY AND "QUALITY OF CARE".

A new technology review consists of a thorough study of the requested service to verify safety and effectiveness, and that it meets current accepted national medical practices and standards of care.

If you order a new technology treatment or service for your patient, which may be considered experimental, your Medical group/IPA will forward the request to WHA's Medical Director for benefit review. WHA's Medical Director will compare your clinical information against new technology assessment criteria developed by Hayes, Inc. Or the request may instead be sent to iMedecs for external review by independent board-certified specialty physicians with relevant medical expertise.

Sometimes WHA's investigation will reveal that the new technology under review is no longer considered experimental and it may be included as a regular plan benefit. If WHA's medical professionals decide a new technology is unproven and your request is denied, you and/or the patient may appeal the decision by contacting WHA's Member Services department.



MEDICATION MANAGEMENT FOR MEMBERS WITH ASTHMA

ASTHMA IS ONE OF THE MOST PREVALENT CHRONIC DISEASES; BECOMING INCREASINGLY MORE COMMONPLACE OVER THE PAST TWENTY YEARS. APPROXIMATELY 23.3 MILLION AMERICANS HAVE ASTHMA AND IT IS RESPONSIBLE FOR OVER 3,000 DEATHS IN THE U.S. ANNUALLY (AMERICAN LUNG ASSOCIATION, 2010). THE MORBIDITY AND MORTALITY RATES CONTINUE TO RISE.



WHA annually measures the “Use of Appropriate Medications for People with Asthma” with HEDIS. The 2011 rate decreased for both children and adults, with WHA’s overall rate of 92.6% now lower than the *California Cooperative Healthcare Reporting Initiative (CCHRI)* average and lower than the NCQA national average.

Pharmacologic therapy is used to prevent and control asthma symptoms, improve quality of life, reduce the frequency and severity of asthma exacerbations, and reverse airflow obstruction. Medications for asthma are usually categorized into long-term controller medications used to achieve and maintain control of persistent asthma and quick-reliever medications used to treat acute symptoms and exacerbations. (NHLBI/NAEPP 2007). Medication adherence could ameliorate the severity of many asthma-related symptoms for children as well as adults (Akinbami, 2009).

NATIONAL HEART LUNG AND BLOOD INSTITUTE/NATIONAL ASTHMA EDUCATION AND PREVENTION PROGRAM

Long-term control medications, including inhaled corticosteroids (ICS), inhaled long-acting bronchodilators, leukotriene modifiers, cromolyn, theophylline, and immunomodulators, are used daily to achieve and maintain control of persistent asthma. The most effective are those that attenuate the underlying inflammation characteristic of asthma. The Expert Panel defines anti-inflammatory medications as those that cause a reduction in the markers of airway inflammation in airway tissue or airway secretions (e.g., eosinophils, mast cells, activated lymphocytes, macrophages, and cytokines; or ECP and tryptase; or extravascular leakage of albumin, fibrinogen or other vascular protein).

Inhaled corticosteroids are the preferred treatment option for mild persistent asthma in adults and children. LTRAs are an alternative, although not preferred, treatment. Long-acting B₂ agonists (LABA) should only be used in combination with ICSs for long-term control and prevention of symptoms in

moderate or severe persistent asthma (*step 3 care or higher in children ≥5 years of age and adults*). There is a strong recommendation against the use of LABAs as monotherapy. Of the adjunctive therapies available, long-acting B₂ agonists is the preferred therapy to combine with ICS in youths ≥12 years of age and adults. The beneficial effects of long-acting B₂ agonists in combination therapy for the great majority of patients who require more therapy than low-dose ICS alone to control asthma (*i.e., require step 3 care or higher*) should be weighed against the increased risk of severe exacerbations, although uncommon, associated with the daily use of long-acting B₂ agonists. The NHLBI/NAEPP guideline strongly recommends against the use of long-acting B₂ agonists for the treatment of acute symptoms or exacerbations.

HEDIS 2012 NEW MEASURE: MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA

Beginning in 2012, WHA will annually measure and report the percentage of members 5 - 64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.

Two rates are reported:

- The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period
- The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period

References

Akinbami, L.J. *The State of Childhood Asthma, United States, 1980–2007*. Advance Data from Vital and Health Statistics. Revised February 16, 2009. *Pediatrics* 123 (Supplement); S131-45. Hyattsville, MD: National Center for Health Statistics. (March 2010)

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National Committee for Quality Assurance. *HEDIS 2012: Healthcare Effectiveness Data and Information Set*. Vol 2, Technical Specifications. Washington, DC: National Committee for Quality Assurance (NCQA).

National Heart Lung and Blood Institute/National Asthma Education and Prevention Program. August 2007. *Measures of asthma assessment and monitoring: Expert panel report 3: guidelines for the diagnosis and management of asthma*. Washington (DC): National Heart Lung and Blood Institute (NHLBI).

ADVANTAGE REFERRAL PROGRAM & STANDING REFERRAL BASICS

IT IS IMPORTANT TO KNOW THAT NOT ALL SPECIALISTS IN WHA'S NETWORK PARTICIPATE IN THE ARP. TO IDENTIFY SPECIALISTS WHO ARE WILLING TO PROVIDE CARE TO PATIENTS FROM ANOTHER MEDICAL GROUP OR IPA, PLEASE CHECK THE CURRENT PROVIDER DIRECTORY AVAILABLE ON WHA'S WEBSITE OR CONTACT MEMBER SERVICES.

ADVANTAGE REFERRAL PROGRAM

WHA members receive most medical care from their primary care physician (PCP). When specialty care is needed, PCPs are encouraged to follow their usual referral practices by sending their patients to specialists within their own affiliated Medical group/IPA. With WHA's *Advantage Referral Program* (ARP), WHA members have the option of receiving specialty care and services from other participating physicians outside their assigned Medical group/IPA when the service is medically necessary and the physician is a WHA participating specialist.

Here are some important details to remember about the ARP referral:

- No prior authorization is required for the initial ARP request from the member's affiliated Medical group/IPA.
- The specialist is allowed to provide routine services such as ordering lab work and plain-film x-rays without obtaining approval.
- Unless the service is allowed under direct access regulations (e.g., annual OB/gynecological or ophthalmology exams), a referral and tracking number is important for billing purposes.
- After the PCP submits an ARP request to his or her affiliated Medical group/IPA, the specialist of choice is notified of the number of visits and timeframe that is allowed to provide the service(s).

- An initial ARP referral allows up to 3 visits with the specialist of choice.
- Surgery or any special tests or procedures recommended by the treating specialist requires prior authorization from the member's assigned Medical group/IPA to ensure coverage.
- After the initial ARP request expires and the member wants to continue receiving care and services from the specialist outside his or her own Medical group/IPA, this must be allowed as long as medical necessity exists, prior authorization is obtained, and the specialist is still a WHA participating provider.

STANDING REFERRALS

If a member has a certain life-threatening, degenerative or disabling condition or disease requiring specialized medical care over a prolonged period of time, including HIV or AIDS, he/she may be allowed a Standing Referral to a specialist. Standing Referrals allow more than the usual number of approved visits the member would be allowed with a typical advantage referral. With a Standing Referral, the specialist can provide more services from a participating specialist or from a specialty care center anywhere in the network that has demonstrated expertise in treating a medical condition or disease involving a complicated treatment regimen that requires ongoing monitoring. Specialists in WHA's provider network with specific expertise in treating HIV or AIDS are noted in the Provider Directory with a special symbol next to their names.

IMMUNIZATION UPDATE

INCREASE IN MEASLES CASES SEEN IN THE U.S.

THE US IS CURRENTLY SEEING THE LARGEST NUMBER OF MEASLES CASES IN 15 YEARS, WITH 156 CONFIRMED CASES REPORTED BETWEEN **JANUARY 1 - JUNE 17, 2011**. MOST OF THESE CASES (136) WERE ASSOCIATED WITH IMPORTATION FROM MEASLES-ENDEMIC COUNTRIES OR COUNTRIES WITH LARGE OUTBREAKS ARE OCCURRING, PRIMARILY COUNTRIES IN EUROPE, AFRICA AND ASIA.

Health care professionals should suspect measles in patients with a febrile rash illness and the clinically compatible symptoms of cough, *coryza*, (runny nose), and/or *conjunctivitis* (red, watery eyes). Patients with these symptoms should be isolated in a private room. Make sure all your healthcare personnel in your work setting who were born 1957 or later have had two doses of *MMR vaccine*, according to CDC recommendations.

For more information visit:

www.cdph.ca.gov/HealthInfo/discond/Pages/Measles.aspx

CHILDHOOD IMMUNIZATION: HEDIS RESULTS 2011

WHA has been collecting *hybrid data* on childhood immunization status for many years, and uses claim/encounter data, immunization registry data, and medical record review. The 2011 combination rates and antigen specific rates show a dramatic decline.

HEDIS Measure	WHA 2010	WHA 2011	CCHRI Average 2011	NCQA Percentile Rank
CIS Childhood Immunization - Combo 2 Children who received four <i>DTaP</i> ; three <i>IPV</i> ; one <i>MMR</i> ; two <i>Hib</i> ; three <i>hepatitis B</i> ; and one <i>VZV</i> vaccination on or before the child's second birthday.	79.46	73.24	79.24	10th
CIS Childhood Immunization - Combo 3 Children who received all antigens listed in Combination 2 and four <i>pneumococcal conjugate</i> vaccinations on or before the child's second birthday.	76.16	68.61	75.75	10th

Childhood Immunization rates for both Combo 2 and 3 decreased significantly from the previous year. Both rates are below the *California Cooperative Healthcare Reporting Initiative (CCHRI)* average, and rank in the 10th percentile nationally.

GAPS IN IMMUNIZATIONS: TIMELINESS, DOCUMENTING, CODING

WHA found performance declined in rates for most antigens in childhood immunizations. The rates for *MMR* (86%) and *VZV* (87%) remain consistently low. The lowest antigen rates were found for *DTaP* (82%) and *PCV* (*Pneumococcal conjugate*) at 81%. Additionally, there was a significant decrease in rates for *IPV* (87%), *HiB* (90%) and *Hepatitis B* (86%).

This decline in immunization rates can reflect lack of timeliness. For example, the 4th *DTaP* and 4th *PCV* vaccines were not given by the child's second birthday. Children requiring a 'catch-up' dosing schedule were not able to receive all of the vaccines in time. There are parents who refuse vaccines, but that remains consistent with prior years and is not the key reason for the dramatic decline in immunization rates this year.

Documentation of the immunization history in the medical record must be complete. One issue is difficulty including immunization history from other providers in certain electronic health records (EHRs). Another issue is incomplete documentation for each of the antigens administered with the combination vaccines.

The use of combination vaccines can also be problematic for coding. The immunization administration may not be consistently coded for all antigens. This may occur with:

- changes in billing procedures
- personnel
- from changing the pharmacy supplier for the antigen(s)

Please have your billing staff carefully review the billing codes for accuracy every year as the requirements change.



ADOLESCENT IMMUNIZATION HEDIS RESULTS 2011

Immunizations for adolescents who turned 13 in 2010 who had one dose of *meningococcal vaccine* and one *tetanus, diphtheria toxoids and pertussis (Tdap/Td) vaccine* between their 10th and 13th birthdays was collected by administrative and medical record review. Results show WHA's Combo I rate improved in 2011, however remains below the *California Healthcare Reporting Initiative (CCHRI) average*, and ranks in the 25th percentile nationally.

Adolescent Immunization	WHA 2010	WHA 2011	CCHRI Average	NCQA Percentile Rank
Meningococcal	42.34	44.53	52.01	10th
Tdap	53.53	56.45	59.78	10th
Combo I (both of the above)	37.71	42.58	49.69	25th

IMMUNIZATION RECORD AND HISTORY

WHA clinical staff have noticed selected practices who have not yet implemented EHR using old or outdated Immunization Record Forms in the patient records. These outdated forms may not include spaces for the newly required immunizations.

To download a copy of the Immunization Record and History Form:

[http://www.cdph.ca.gov/programs/immunize/Documents/DHS-8608-IMM542P_\(1-07\)WEB.pdf](http://www.cdph.ca.gov/programs/immunize/Documents/DHS-8608-IMM542P_(1-07)WEB.pdf)

2011 IMMUNIZATION SCHEDULES AVAILABLE VIA THE PROVIDER SECTION OF WHA'S WEBSITE

To access the 2011 Provider Guidelines and Immunization Schedules (PHGS) on WHA's website, westernhealth.com. select *Providers* ► *Preventive Health Guidelines* ► *Immunization Recommendations*.

Or visit: mywha.org/phgs

VACCINE ADMINISTRATION SAFETY

The *California Department of Public Health Immunization Branch* has released new materials on immunization safety via their web site www.eziz.org. "*Immunization Techniques; Best Practices for Infants, Children and Adults*" is a 25-minute training video, that focuses on skills and techniques needed for vaccine administration. It can be used for new employee orientation or for a refresher for experienced staff.

The video can be accessed at:

http://eziz.org/pages/eziz_training.html

Other materials available on the website:

Vaccine Safety 10 Facts for Medical Assistants:

<http://www.eziz.org/PDF/IMM-1016.pdf>

Talking to Parents about Vaccine Safety:

<http://www.eziz.org/PDF/IMM-915.pdf>



Immunization Record and History

PATIENT NAME (Last Name, First Name, Middle Initial)			NUMBER
BIRTHDATE	<input type="checkbox"/> Male <input type="checkbox"/> Female	KNOWN REACTIONS TO VACCINES/ALLERGIES	PRACTICE NAME/ADDRESS
VACCINES FOR CHILDREN (VFC) ELIGIBILITY (check one) <input type="checkbox"/> CHDP/Medi-Cal eligible <input type="checkbox"/> No health insurance <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> (Only federally qualified and rural health centers) Health insurance does not cover IZs <input type="checkbox"/> Not eligible			

If a combination vaccine (e.g., DTaP+IPV+HepB or HepB+Hib) is used, record dose in each section.

VACCINE Circle one	DATE GIVEN*	MANUFACTURER AND LOT NUMBER	ADMINISTERED BY	SITE**	VACCINE	DATE GIVEN*	MANUFACTURER AND LOT NUMBER	ADMINISTERED BY	SITE**
				VIS I.D.†					VIS I.D.†
HepB 1				<i>IM</i>	Pneumo Conj 1				<i>IM</i>
HepB 2				<i>IM</i>	Pneumo Conj 2				<i>IM</i>
HepB 3				<i>IM</i>	Pneumo Conj 3				<i>IM</i>
HepB				<i>IM</i>	Pneumo Conj 4				<i>IM</i>
Rotavirus 1				<i>oral</i>	IPV 1				<i>IM or SC</i>
Rotavirus 2				<i>oral</i>	IPV 2				<i>IM or SC</i>
Rotavirus 3				<i>oral</i>	IPV 3				<i>IM or SC</i>
DTaP/DT/Td/Tdap 1				<i>IM</i>	IPV 4				<i>IM or SC</i>
DTaP/DT/Td/Tdap 2				<i>IM</i>	MMR 1				SC
DTaP/DT/Td/Tdap 3				<i>IM</i>	MMR 2				SC
DTaP/DT/Td/Tdap 4				<i>IM</i>	Varicella 1				SC
DTaP/DT/Td/Tdap 5				<i>IM</i>	Varicella 2				SC
Td/Tdap (boosters over)				<i>IM</i>	HepA 1				<i>IM</i>
HIB 1				<i>IM</i>	HepA 2				<i>IM</i>
HIB 2				<i>IM</i>	TB SKIN TESTS				
HIB 3				<i>IM</i>	DATE GIVEN	TYPE	DATE READ	IMPRESSION	
HIB 4				<i>IM</i>		<input type="checkbox"/> Mantoux <input type="checkbox"/> Other		<input type="checkbox"/> Negative <input type="checkbox"/> Positive (mm _____)	

* **Date Given** is the date you gave the patient the Vaccine Information Statement (VIS) and you administered the vaccine.
 ** **Site:** Abbreviations are LD=left deltoid or left outer upper arm, LT=left thigh, RD=right deltoid or right outer upper arm, RT=right thigh. Proper route indicated by italics: IM=intramuscular, SC=subcutaneous.
 § **MCV4** is given IM and **MPSV4** is given SC.

† **VIS**—Vaccine Information Statement. Each VIS has an issue date in the lower corner; record the VIS issue date here. The VIS should be given to the patient/parent before each dose of vaccine is administered. Each VIS can be downloaded from www.cdc.gov/nip/publications/VIS.
 Note: If you are recording a vaccine given elsewhere, record date dose was given, write in "elsewhere" or "transcribed" and/or name of provider.

DIABETES UPDATE

CDC REPORTS DIABETES AFFECTS 25.8 MILLION PEOPLE, 8.3% OF THE U.S. POPULATION (All ages 2010)

WHA HEDIS RESULTS FOR DIABETES SHOWED SOME IMPROVEMENT IN SEVEN OF NINE MEASURES; HOWEVER PERFORMANCE REMAINS BELOW THE CALIFORNIA COOPERATIVE HEALTHCARE REPORTING INITIATIVE (CCHRI) AVERAGE IN ALL EIGHT REPORTED MEASURES.

WHA's Diabetic retinal eye exam and *HbA1c* test rates show improvement yet rank below the NCQA national average, and remain priorities. There is a new indicator for blood pressure control to measure the rate for BP <140/80.

Comprehensive Diabetes Care	WHA HEDIS 2010	WHA HEDIS 2011	CCHRI Average 2011	NCQA Percentile Rank
HbA1c Testing	87.04	88.69	90.63	25th
* HbA1c Poor Control (>9 %)	24.64	22.99	22.04	50th
HbA1c Control (< 8 %)	68.87	65.50	65.62	50th
HbA1c Control (<7%)	46.08	45.21	NR	50th
Diabetic Retinal Eye Exam	53.47	55.29	60.70	25th
LDL – C Screening	84.85	87.41	88.24	50th
LDL – Level < 100	47.81	50.73	54.26	50th
Monitor Nephropathy	85.58	87.04	88.26	50th
BP Control (<140/90)	69.71	70.26	70.54	50th
BP Control (<140/80) New in 2011		47.08	NR	NR

* Lower is better for this measure



NEW FINDINGS ON DIET AND EXERCISE INTERVENTIONS

A study on lifestyle intervention strategies after recent type 2 diabetes diagnosis was recently published in *The Lancet* and presented at the ADA's *Scientific Sessions* with some unexpected results. The study, *Early Activity In Type 2 Diabetes (ACTID)*, looked at the comparison of diet or diet and exercise against "usual care". The authors defined "usual care" as a physician who gives an initial diet consultation and a follow up at 6 and 12 months. The two lifestyle intervention strategies were dietary consultations every 3 months with monthly nurse support and the second strategy included the same dietary intervention with a physical activity program. The researchers looked at blood glucose concentration (HbA1c) and blood pressure at 6 months after the diagnosis. The study's results reinforced the general understanding that treating diabetes with diet and exercise interventions is superior to "usual care." Unexpectedly, the study did not see a better outcome in the combined diet and exercise groups compared to diet intervention alone. With these results the investigators proposed that in time of budgetary constraint diet intervention alone is a legitimate first-line approach to diabetes control.

PROVIDER TOOLS AND RESOURCES

CALIFORNIA MEDICAL ASSOCIATION (CMA) FOUNDATION'S 2ND EDITION OF THE DIABETES AND CARDIOVASCULAR DISEASE PROVIDER REFERENCE GUIDE – 2011

The *CMA Foundation* has just released an updated *Provider Reference Guide for Diabetes and Cardiovascular Disease (PRG)*. The PRG is a comprehensive resource containing the most current evidence based clinical guidelines, practical tips and patient education handouts to support high quality, patient centered care. It is targeted towards physicians, nurses, pharmacists and other healthcare providers who care for patients with diabetes. It can also be used by quality improvement leaders who support practices in the provision of high quality, evidence-based care.

To view the entire guide and tools visit:

www.thecmafoundation.org/projects/aped/NewPatientResource.aspx

WHAT'S NEW IN THE 2ND EDITION OF THE PRG?

- *Diabetes Care Guidelines/Flow Sheet* – sample included, also available as a download from the CMA Foundation website. <http://www.thecmafoundation.org/projects/aped/TABLE%2013%20Diabetes%20Care%20Guidelines%20Flow%20Sheet.pdf>
- Identification and management of prediabetes
- An updated "Management" chapter that integrates blood glucose, hypertension and hyperlipidemia management all in one chapter (reflecting a more comprehensive management of diabetes)
- Adult outpatient insulin guidelines for type 2 diabetes, including a decision matrix, from the *Diabetes Coalition of California*
- Physical activity guidelines for type 2 diabetes
- Tips to improve medication adherence
- Updated pharmacotherapy grids to treat and manage *diabetes, hypertension and dyslipidemia*
- Updated ICD-9-CM codes

If you are interested in receiving a CD-ROM of the guide at no cost, please contact Joe Mette at jmette@thecmafoundation.org

DIABETES & CARDIOVASCULAR DISEASE PATIENT EDUCATION TOOLKIT AVAILABLE

- The *American Diabetes Association*, *American College of Cardiology*, and *Preventive Cardiovascular Nurses Association* have released their *Reducing Cardiometabolic Risk Patient Education Toolkit*; the toolkit consists of 29 patient handouts available in English and Spanish.
- The educational handouts cover topics such as *cardiometabolic risk reduction, pre-diabetes, diabetes, and CVD*.
- The toolkit is an excellent resource to help your patients understand and work with you to better manage their cardiometabolic risk factors by providing them with the information and organizational tools they need.

You may download copies of the individual handouts on their website or request a CD of all the handouts at <http://professional.diabetes.org/ResourcesForProfessionals.aspx?cid=77080>

Diabetes Care Guidelines/Flow Sheet



Name _____ MR # _____ D.O.B. _____
 Language _____ Race/Ethnicity _____

Clinical Priorities	Parameters	Frequency	Goal/ Recommendation	Date/ Results:	Date/ Results:	Date/ Results:	Date/ Results:
History, Physical and Emotional	Blood Pressure	Every Visit	<130/80 mm/Hg				
	Weight	Every Visit	BMI <25 kg/m ² ; reduce weight by 5%-10% if overweight				
	Foot exam	Every Visit	Inspect skin; teach protective foot behavior if sensation diminished				
	Foot exam-monofilament	Annually	Prevention of ulceration and amputations				
	Dilated Eye Exam	Annually	Retinopathy prevention				
	Dental	Bi-Annually	Assess oral symptoms/ refer to dentist				
	Depression	Annually	Assess for mood disorders; suggest support groups/counsel/referral				
	Medication Review (diabetes meds, statin, ACE/ARB and/or aspirin)	Every visit	Optimize glycemic control and for the primary or secondary prevention of CVD and/or management of HTN and hyperlipidemia; reconcile medication list; discuss adherence issues				
	Tobacco Status: _____ Never _____ Former _____ Current Quit Date: _____ If current smoker, refer to California Smokers' Helpline at 1-800-NO-BUTTS						
General Care	Periodic H&P/ Pap or Prostate	As indicated	Early detection of cervical and prostate cancer				
	Mammogram/ Chest X-Ray	Every 1 - 2 years	Early detection of breast cancer; screening to begin at age 40 or 50 [†]				
	Colorectal Cancer	After age 50	Early identification of colorectal cancer				
	EKG	As indicated	Detection of cardiac abnormalities				
Lab	A1C	Quarterly	<7% for most patients*				
	Albumin/Creatinine Ratio	Annually	Check spot urine for albumin and creatinine, calculate ratio $\geq 30 \mu\text{g alb/mg creatinine}$ is abnormal				
	Serum Creatinine for eGFR	Annually	Estimate glomerular filtration rate (GFR) to stage the level of chronic kidney disease (CKD)				
	LDL	Annually	< 100 mg/dL; <70 mg/dL (optional goal)				
	Triglycerides	Annually	<150 mg/dL				
	HDL	Annually	>40 mg/dL in men; > 50 mg/dL in women				
	Non-HDL	Annually	<130 mg/dL; <100 mg/dL (optional goal)				
	Total Cholesterol	Annually	< 200 mg/dL				
Vaccine	Flu Vaccine	Encourage vaccination annually upon availability of vaccine					
	Pneumovax	Revaccinate >65 years old if initial vaccine given >5 years ago and < 65 years old					
	Tetanus/ PPD	Vaccination against tetanus; determine exposure to TB					
	Tdap/ Pertussis	Vaccination against tetanus, diphtheria & pertussis					
Self Management			Goals	Patient Goals			
Self-Glucose Monitoring			Pt. to monitor glucose as necessary to minimize risk of hyper/hypo glycemic episodes; review and check patient log book for accuracy				
Physical Activity			150 minutes of moderate to vigorous exercise a week				
Nutrition			Advise weight reduction if BMI ≥ 25 ; refer to dietician/MNT				
Foot Exam			Review foot inspection instructions with patient				
Medication Management/Adherence			Discuss barriers/solutions to adherence; reconcile medication list				

[†] For women at average risk of breast cancer, the US Preventive Services Task Force recommends mammograms every 2 years beginning at age 50 while the American Cancer Society recommends yearly mammograms beginning at age 40.
 * More or less stringent A1c values may be appropriate dependent on individual history, risk factors and length of disease, among other considerations.
 Sources: American Diabetes Association, *Standards of Medical Care in Diabetes, 2011* and the American Association of Clinical Endocrinologists, *Medical Guidelines for Developing a Diabetes Mellitus Comprehensive Care Plan, 2011*
 Notes: 1) Any application of these recommendations should be made in consideration of the needs, conditions and circumstances of each individual patient. 2) This flow sheet is included in the CMA Foundation's *Diabetes and Cardiovascular Disease Provider Reference Guide (2nd ed.)*, 2011.

MEDICAL RECORD

MANAGEMENT STANDARDS

WHA IS REQUIRED TO ESTABLISH AND MAINTAIN STANDARDS FOR MEDICAL RECORD DOCUMENTATION AND MANAGEMENT OF MEDICAL RECORDS IN THE AMBULATORY SETTING BY THE DEPARTMENT OF HEALTH CARE (DMHC).. WHA CONDUCTS ANNUAL AUDITS OF YOUR MEDICAL RECORD KEEPING PRACTICES AGAINST THE FOLLOWING STANDARDS

Medical Group/IPA practitioners must have written processes or policies/procedures addressing the management of medical record systems/documentation standards/medical record keeping practices at practitioner sites that include specifics related to the following standards. These documents are made available to the health plan, regulatory and accreditation agencies upon request.

Medical Group/IPA practitioners must maintain an individual hard-copy or electronic medical record (EMR) for each member. EMR or member data must:

- Be password protected
- Contain a list of signatures by initials
- Include a system to incorporate electronic data into hardcopy medical records when both are used

The medical record keeping system must ensure:

- The medical record is made available to the practitioner at the time of a member encounter,
- Information can be retrieved easily and promptly,
- Information is filed in the medical record timely (reports such as lab, x-ray, consultations, etc),
- Hard-copy records are filed systematically either alphabetically, numerically, or color coded.
- Hard-copy medical records and other protected health information are collected after use and stored in a secure central place accessible only to authorized personnel.

Hard-copy and EMR that are in use, are maintained in such a manner that the contents cannot be viewed by persons unauthorized to access such records.

Medical Group/IPA practitioners and their staff have a documented system for tracking hard-copy medical records when a record is removed from the centralized filing system. (Mental health and substance abuse records may be filed separately from the member's main medical record.)

Medical Group/IPA practitioners and their staff have a documented system in place to follow-up on referrals, procedures or tests cancelled for cause by the member, and laboratory, x-ray, consultation reports or other information that hasn't been reviewed.

Medical Group/IPA practitioners and their staff have a documented system in place to ensure that inactive records and purged hardcopy and EMR data are archived in a manner that meets federal and state requirements. These records remain accessible for a period of time consistent with those regulations (currently five years) and to age of majority for minors.

Medical Group/IPA practitioners and their staff have a documented system in place to obtain *Consent for Treatment* given by the member, parent, or guardian at the initial office visit by signing a *Consent to Treatment* form filed in the member's medical record. Any special consent forms signed must be present in the member's medical record.

Release of hard-copy or EMRs are provided only by Medical Record Department or Health Information Management staff or personnel with responsibility for such release of information. There is documented evidence that staff have received periodic training regarding HIPAA Privacy Regulations and maintaining confidentiality of member information.

Member protected health information is released in accordance with the HIPAA Privacy regulations and any other applicable federal or state regulations. Authorization forms permitting the release of medical records specify all of the items set forth in the HIPAA regulations (including the type of information requested, name of requestor, name/ID/DOB of member, dated signature of member or authorized representative, date of request, and date of release). Release of information in response to a court order or other legal process is reported to the member when required by HIPAA.

MEDICAL RECORD DOCUMENTATION STANDARDS

WHA CONDUCTS ANNUAL MEDICAL RECORD DOCUMENTATION AUDITS AGAINST THE FOLLOWING STANDARDS. EACH PRIMARY CARE PHYSICIAN WITH 50 OR MORE MEMBERS WILL BE AUDITED ONCE EVERY THREE YEARS. PLEASE REVIEW THE STANDARDS TO ENSURE THEY ARE BEING APPLIED IN YOUR DAILY PRACTICE.

Patient name or ID present on each page

Consultations are documented as appropriate.

Medication allergies and adverse drug reactions are present

Clinical findings and evaluation are present every visit, including: diagnoses, appropriate history & physical findings

Pathology, laboratory and other reports are recorded

Provider is identifiable for every entry

Case management and/or multidisciplinary team notes are present if applicable

PROVIDER DISPUTE RESOLUTION

(PDR) PROCESS FOR CLAIMS

CONTRACTED AND NON-CONTRACTED PROVIDERS CAN DISPUTE CLAIMS THROUGH THEIR MEDICAL GROUP/IPA OR WHA'S (PLAN) PROVIDER DISPUTE RESOLUTION PROCESS.

To ensure timely resolution, PDRs that were contested, adjusted or denied at the Plan level or by the capitated Medical Group/IPA must be submitted electronically or in writing and include complete information.

Full instructions are available on the PDR form and in WHA's PDR policy and procedure, which can be accessed at mywha.org/pdr

MEDICAL GROUP/IPA LEVEL DISPUTE

If a dispute involves a denial of a claim or an adjustment that was originally rendered by an Medical Group/IPA, the dispute must be filed with the Medical Group/IPA that issued the decision.

If the dispute involves a medical necessity decision rendered by the Medical Group/ IPA or other utilization management issue, providers have the right to file a dispute at the Plan level within 60 working days after issuance of a final determination by the Medical Group/ IPA. This means that in some cases, providers

have a second level reconsideration mechanism available, if they are dissatisfied with the initial claim dispute decision made by the Medical Group/IPA.

Contact your Medical Group/IPA for a copy of the PDR request form and for additional information about the PDR process, or check their website.

PLAN LEVEL DISPUTE

A provider may file a dispute at the Plan level for two reasons:

- The provider receives an initial denial or claim adjustment at the plan level; or
- The provider is dissatisfied with the Medical Group/ IPA dispute outcome and the case involves medical necessity or utilization management. These decisions are made by qualified physicians.

To file a dispute with WHA, complete a PDR request form is available on WHA's website. Receipt of the completed form will be acknowledged within prescribed timeframes (within 2 working days for electronic submissions and 15 days for written submissions). WHA will process the request and notify the provider of the outcome in writing, usually within 45 working days of receipt.

PRIOR AUTHORIZATION (PA) OF SERVICES

UPON ENROLLMENT, ALL NEW WHA MEMBERS MUST SELECT A PRIMARY CARE PHYSICIAN (PCP). THE PCP COORDINATES CARE, PROVIDES DIRECT TREATMENT AND MAKES REFERRALS TO SPECIALTY PROVIDERS WHEN NECESSARY. ALL NON-URGENT OR NON-EMERGENCY CARE SHOULD BE RECEIVED FROM THE PATIENT'S PCP OR FROM ANOTHER WHA NETWORK PROVIDER.

As you know, our PCPs and specialists are participants in a medical group or independent practice associations (IPAs). Your Medical Group/ IPA has a contract with WHA to provide health care services to our members. Certain services you may recommend require prior authorization from your affiliated Medical Group/IPA or from WHA to ensure coverage. Other services, such as urgent/emergency care, in-network annual eye exams and routine gynecological and obstetric care, do not require prior authorization as long as a network physician provides them. You (PCP or specialist) or someone at our Medical Group/ IPA office should know when prior authorization is needed.

When your patient needs specialty care and a referral is required, you should submit a request to your affiliated Medical Group/IPA for review, tracking or decision-making. Clinical professionals at the Medical Group/IPA will evaluate the request for benefit coverage and medical necessity then notify the member, PCP and specialist of the decision.

If a request is denied or modified by the physician reviewers, the patient, PCP and listed specialist are notified in writing of the decision and reasons to support the decision. The patient or a patient's representative acting on the patient's behalf, including a supportive physician, may appeal the decision. If the patient is dissatisfied with WHA's appeal outcome, legal requirements may allow an external organization to evaluate the patient's case and make an independent decision, which is binding on the health plan.



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Look for Updated Clinical Guidelines on **WHA's Website**

WHA'S QUALITY IMPROVEMENT COMMITTEE
RECENTLY APPROVED THE FOLLOWING GUIDELINES.

CORONARY ARTERY DISEASE:

- Alere's Summary of the Guidelines for the Management of CAD

DIABETES:

- American Diabetes Association Standards of Medical Care in Diabetes 2011
- Alere's Summary of ADA's Standards of Care 2011

These guidelines can be viewed, downloaded and/or printed at mywha.org/cpgs. If you would like a written copy mailed, faxed or emailed to you, please contact (916) 563-6006 for assistance.

