Ohio Immunization Registry Easier to Use

The Ohio Department of Health recently improved the functionality and ease of use of ImpactSIIS, the Statewide Immunization Information System. This online tool can help you save time, reduce paperwork and keep patients coming back.

The new and improved ImpactSIIS allows you to:
- Retrieve and print an immunization record in less than a minute.
- Find out which vaccines are due at a glance.
- Analyze data for quality improvement activities, including HEDIS measures.
- Generate pre-appointment and missed appointment notices.
- Access information about vaccine inventory management.
- Obtain sample refrigerator/freezer temperature logs.
- Research immunization histories.
- Access links to immunization reference sites and updates.

Birth information of children born in Ohio is automatically entered into the ImpactSIIS database through a link with electronic birth records. As immunization information is added to the patient profile, a comprehensive vaccine record from birth through adulthood is created. ImpactSIIS is used by all County Health Department Clinics, more than 370 private Vaccine for Children (VFC) providers and more than 230 private non-VFC providers. Schools and hospitals also participate.

ImpactSIIS provides hands-on training and set-up as well as access to a call center for help. Visit impactsis.org to learn how to become an authorized user of this free service that saves time and improves the quality of care.

For additional information about immunization registries, access the Centers for Disease Control and Prevention’s IIS website, which includes an overview of the practical usage and benefits of immunization registries for patients of all ages. The site also provides state-specific legislative news, technical and equipment requirements and staff contact information. Visit cdc.gov/vaccines/program/iis/default.htm to view this valuable resource.
Consider Antidepressant Side Effects When Prescribing

Depression is a common medical condition encountered by physicians every day. Up to 10 percent of outpatient visits to primary care physicians’ offices meet the diagnostic criteria for major depressive disorder.

When depression is accurately diagnosed, with the help of standardized screening tools, several treatment approaches should be considered:
- Psychotherapy
- Psychopharmacological treatment
- Referral to a behavioral health specialist

Primary care physicians write more than 75 percent of all antidepressant prescriptions. Researchers have found that aggressive marketing of antidepressants and widespread availability may encourage practitioners to opt for psychopharmacological therapy when full criteria are not met or when other treatment modalities may be considered. All treatment options should be considered, and patient education is essential in all cases.

Patient compliance is a barrier to effective treatment. A 2003 study showed that as many as 70 percent of primary care patients fail to adhere to either short- or long-term antidepressant treatment. Patients treated with antidepressant medications can develop side effects, which often occur before improvement in mood can be expected. Undesirable side effects are among the main reasons patients discontinue their medications.

When functional impairment is not associated with a depressed mood, some experts recommend psychotherapy or support groups as the initial treatment, while monitoring symptoms to see if they lessen or if pharmacological treatment might be necessary. When antidepressant treatment is warranted, several factors may affect the choice of medications. These factors should include the side effect profile, past experience in the patient or a family member and cost. The goal is to minimize undesirable side effects while targeting patient-specific depressive symptoms. Aggressive side-effect management can improve adherence and prevent premature discontinuation.

The following are some antidepressant prescribing principles:
- Do not rush to prescribe antidepressants for patients who do not meet the full criteria for major depressive disorder. Monitoring with supportive treatment may lead to symptom remission.
- Educate patients about potential side effects, and remind them there will be a delay in treatment response. Patients may experience side effects before they receive benefits from treatment.
- Plan at least three follow-up visits during the first three months after the patient starts on the antidepressant medication, with the first visit occurring within seven to 10 days to assess how the patient is tolerating the medication.
- Taper antidepressants gradually when discontinuing them to monitor for a potential return in symptoms and to avoid discontinuation symptoms.
- Consider combining psychotherapy with antidepressant medications, especially for patients with recurrent depressive episodes.

Managing Patient Safety – ePrescribing Can Help

The Institute of Medicine 2006 report states at least 1.5 million preventable adverse drug events occur each year in the United States. Electronic prescribing (ePrescribing) can help reduce that number by putting critical clinical information at the fingertips of physicians at the point of care, where it can do the most good. ePrescribing is a proven way of enhancing patient safety while reducing administrative cost and reducing the workload in the physician’s office.

Physicians can use a desktop computer, handheld device or personal computer tablet to electronically submit a prescription to the pharmacy of choice.

Benefits of ePrescribing include:
- Reducing potentially harmful drug interactions by alerting physicians of possible risks.
- Eliminating medication errors due to illegible handwriting.
- Providing physicians with formulary information when writing the prescription, resulting in an increase in the use of generics and preferred drugs, which translates into savings for the patient.
- Furnishing physicians with benefit plan details at the point of prescribing so that changes will not be needed when the prescription is presented at the pharmacy.

For more information about using ePrescribing for our members, please contact Steve Harry, Product Management Specialist, Pharmacy Services, at 216.687.7785.


Clinical Practice Guideline Update

The following Clinical Practice Guidelines have been updated and are available for providers to access on our websites:
- Clinical Practice Guidelines for Asthma 2010
- Clinical Practice Guidelines for COPD 2010

All available guidelines can be easily accessed by visiting our websites and selecting the Providers tab. Select Tools & Resources then Guidelines. Other guidelines include:
- Alcohol Screening
- Continuity and Coordination of Medical Care
- Diabetes
- Heart Failure
- Attention Deficit/Hyperactivity Disorder
- Coronary Artery Disease
- Cholesterol
- Hypertension
- Depression Major: Primary Care Provider
- Depression Major: Behavioral Health Provider
- Continuity of Care Behavioral Health Provider
- Musculoskeletal and Chronic Pain
- Tobacco Dependence
- Preventive Care Guidelines (in compliance with recent healthcare reform mandates)

If you would prefer to receive a copy of any of our guidelines by mail, call the Clinical Quality Improvement (CQI) department at 800.586.4523 or write to us at Medical Mutual, MZ: 01-5B-7501, 2060 East 9th Street, Cleveland, Ohio 44115, and indicate which guidelines you would like to receive.
Annual HEDIS Review

Focus on Hypertension and Postpartum Care

In 2011, we will again conduct the annual Healthcare Effectiveness Data and Information Set (HEDIS) review. This project involves gathering information from providers participating in our SuperMed network. The members are selected randomly and meet specific HEDIS measurement criteria established by the National Committee for Quality Assurance (NCQA).

We strive to continually enhance member access to care and facilitate quality of care improvements. Through HEDIS studies, we are able to evaluate use of preventive screening, diabetes care, hypertension control, prenatal/postpartum care and immunization status.

Hypertension, defined as any blood pressure greater than 140 mmHg systolic or 90 mmHg diastolic, is a major issue affecting a large portion of our members.

Please assist us in our improvement efforts by:

- Ensuring that accurate blood pressure measurements are performed and documented in the medical record.
- Re-measure the blood pressure in any patient with an initial reading greater than or equal to 140 mmHg systolic or 90 mmHg diastolic and include the re-measurement in the medical record.

Timeliness of postpartum care, defined as a postpartum visit that occurs between 21 days (three weeks) and 56 days (eight weeks) after delivery, is another area where your assistance will help us improve quality.

Our past HEDIS studies have shown postpartum visits to either be missed altogether or fall outside of the recommended timeframe. An incentive, in addition to the global obstetrical fee, has been attached to the use of the following obstetrical Category II CPT codes:

**0500F: Initial Prenatal Visit within the first 12 weeks of pregnancy**

The initial prenatal care visit includes documentation of the following:

- History and physical exam
- Pelvic exam
- Blood work
- Pregnancy risk assessment

**0503F: Postpartum Visit between 21 and 56 days after delivery**

The postpartum care visit includes documentation of one or more of the following:

- Pelvic exam or
- Evaluation of weight, blood pressure, breasts and abdomen or
- Notation of postpartum care

Please assist us by scheduling postpartum visits to occur between 21 and 56 days of delivery.

Detailed information about this project will be mailed to providers in February or early March 2011. We value you as an important part of this process and thank you in advance for your cooperation.
Follow-Up Improves Asthma Outcomes

A prior hospitalization or emergency department (ED) visit for treatment of asthma is the leading risk factor for subsequent exacerbations. National guidelines recommend a follow-up office visit within one to four weeks after hospitalization or ED visit for acute asthma. When a follow-up visit occurs within two weeks of discharge, providers have the opportunity to optimize the treatment plan in an outpatient setting.

To ensure timely follow-up, our objective is to have all members visit their provider within two weeks following hospitalization or an ED visit for acute asthma.

Administrative medical claims data and utilization review information were used to identify asthmatic members hospitalized or seen in the ED and subsequently seen by the treating physician within two weeks, four weeks and six weeks.

<table>
<thead>
<tr>
<th>Results: 2009 Measurement Year</th>
<th>Follow-Up Office Visit (N=937)</th>
<th>After Hospitalization (N=3884)</th>
<th>Combined Follow-Up Rate (N=4821)</th>
<th>Combined Follow-Up Rate Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 2 weeks</td>
<td>56%</td>
<td>39%</td>
<td>42%</td>
<td>60%</td>
</tr>
<tr>
<td>Within 4 weeks</td>
<td>70%</td>
<td>51%</td>
<td>51%</td>
<td>75%</td>
</tr>
<tr>
<td>Within 6 weeks</td>
<td>75%</td>
<td>53%</td>
<td>57%</td>
<td>90%</td>
</tr>
</tbody>
</table>

Interventions to improve follow-up care for our asthmatic members include:
- Member education about the importance of seeing their primary care provider after an acute asthma event
- Notification of providers when a member has been hospitalized or seen in the ED to assist with scheduling a timely follow-up visit

Thank you for your assistance in ensuring timely follow-up care for our members with asthma.

Influenza Update 2010 – 2011

As influenza season continues, we offer the following flu-related updates:
- The Advisory Committee for Immunization Practices (ACIP) recommends that all people ages 6 months and older receive an annual seasonal influenza vaccination.
- The trivalent formula for 2010-2011 contains H1N1 as a component. There is no separate H1N1 vaccine.
- Due to the expanded coverage recommendation, expect demand to increase. Order accordingly through your usual ordering mechanism.
- The federal government is not providing H1N1 flu vaccine this year as was done for the 2009-2010 season.
- The Food and Drug Administration (FDA) approved a new test for the diagnosis of H1N1 infection. The CDC Influenza 2009 A (H1N1) pdm Real-Time RT-PCR Panel (IVD) replaces the RT-PCR test that received emergency use authorization in 2009. This new assay has been optimized to detect infection with both a sensitivity and specificity of greater than 96 percent.
- People at highest risk should be prioritized for flu vaccination. These include: all people age 50 and older, all children age 6 months through age 18, all people ages 19 through 49 with a chronic condition, residents of long-term care facilities, pregnant women, healthcare workers, and caregivers and household contacts of infants younger than 6 months.

For details, visit cdc.gov/vaccines/recs/provisional/downloads/flu-vac-mar-2010-508.pdf or cdc.gov/media/pressrel/2010/r100622.htm.
A recent Medco study of asthmatics examined the prevalence of long-acting beta-agonist (LABA) use (Serevent® Dulera®, Foradil®) as sole therapy. Treating asthma patients with LABAs alone has been questioned due to potential safety risks, including severe exacerbation of asthma symptoms leading to hospitalizations and even death.

In a 2008 review, John Oppenheimer, MD, and Harold S. Nelson, MD, wrote:

“It’s uncertain whether these deleterious effects are due to some rare susceptibility to these drugs or, more likely, that this is the consequence of monotherapy with long-acting \( \beta_2 \)-agonists controlling the signs and symptoms while masking inflammations.”

Clinical practice reveals a disconnect between safety warnings and prescribing

In 2008, the FDA began requiring product label warnings about the use of LABAs as monotherapy and instituted national prescribing guidelines calling for use of these agents only when asthma cannot be managed with other medications. A 2009 physician survey including multiple specialties confirmed widespread awareness of the warnings but there were differences in how the warning influenced clinical practice?

Medco claims data identify LABA prescribing patterns across specialties

Medco evaluated medication claims data (April 1, 2009 – September 30, 2009) for asthmatics with continuous drug coverage in 2009 and identified 9,841 patients taking LABAs either as monotherapy or in combination with other controller medications.

LABA monotherapy was identified in 30.9 percent (3,043/9,841) of the study population across all physician specialties. Physicians from an asthma-related specialty (allergy-immunology and pulmonary) were 43 percent less likely to use LABA monotherapy than a non-asthma specialist. (20.9 percent vs. 36.4 percent, respectively). LABA monotherapy was more common among adolescent patients (<12 years 19.3 percent; 12 to 17 years 38.1 percent; 18 to 45 years 35.1 percent; and >45 years 27.5 percent).

Discussion

Despite documented physician awareness of safety risks, LABA monotherapy remains prevalent, albeit less so among patients treated by asthma-related specialists. Retrospective analysis of claims data did not permit discrimination between physician prescribing of monotherapy and patients choosing to fill only LABA prescriptions despite the presence of prescriptions for ICS or leukotriene modifiers. It is strongly recommended that providers educate patients about the safety risks of using LABAs without concomitant use of controller medications.

For additional information, access the National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma located at the links below:

- To view the PDF, please visit: nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf.
- To visit the United States Department of Health and Human Services’ website, please visit: nhlbi.nih.gov/guidelines/asthma/asthgdln.htm.
Never Event?

Inappropriate use of modifiers can adversely affect reimbursement – especially if the modifier indicates a “never event.”

Healthcare Common Procedure Coding System (HCPCS) Modifiers PA, PB and PC have been created to report erroneously performed surgical procedures on the Health Care Financing Administration (HCFA) 1500 claim form. Surgical or other invasive procedures intended to treat a particular medical condition are not reimbursable when the provider performs:

■ A procedure on the wrong body part
■ A procedure on the wrong patient
■ The wrong procedure

In the event that any of the above situations occurs, providers are required to add one of the following applicable modifiers pertaining to the erroneous procedure(s) to all lines on the HCFA 1500 claim form:

■ **Modifier PA**: Surgery performed on the wrong body part
■ **Modifier PB**: Surgery performed on the wrong patient
■ **Modifier PC**: The wrong surgery was performed on the patient

If the letters PA, PB or PC are used on a professional claim, payment will be denied. Some providers are incorrectly using the PC modifier to reflect the Professional Component of a service instead of modifier 26 when a procedure is a combination of a Professional Component and Technical Component. Although TC has been established as the correct modifier to indicate performance of the Technical Component of a procedure, PC is **not** the correct modifier to indicate performance of the Professional Component.

In other instances, providers are using the modifier field to add verbiage to clarify the service, such as using the word “partial,” which the system reads as “PA,” indicating the surgery was performed on the wrong body part.

When billing for surgical services:

■ **Use modifier 26 when coding for the Professional Component of a service, not “PC”**
■ **Use only CPT modifiers (no additional verbiage) in the section of the HCFA 1500 claim form**

Additional information about the appropriate use of never event modifiers can be obtained on the Medicare website, cms.gov/MLNMattersArticles/downloads/MM6718.pdf.
Diabetes and Depression

Clinicians face daily challenges when helping diabetic patients control their disease. All too often, measures of glucose control do not improve and questions arise about adherence to the recommended treatment plan. Mood disorders, like major depression, may be interfering with the prescribed treatment plan.

It is estimated that depression occurs nearly twice as often in patients with diabetes when compared to the general population, potentially affecting 25 percent of all people with diabetes. This can lead to suboptimal glycemic control and increased risk of complications due to poor self-management of diet and exercise and medication noncompliance. Depression may also contribute because it can be associated with a sedentary lifestyle, obesity and smoking.

A longitudinal study published in *Diabetes Care*, February 2010, tracked microvascular and macrovascular complication rates in type 2 diabetics over a five-year period. Diabetics with major depression had a 36-percent higher risk of microvascular complications and 25-percent higher risk of macrovascular complications compared to those without depression. The Pathways Epidemiologic Follow-Up Study also showed that diabetic patients with co-existing depression are at higher risk.

While more research is necessary to identify underlying mechanisms of the relationship between depression and insulin sensitivity, it is clear that identifying and treating depression can improve quality of life and contribute to eliminating the barriers of poor lifestyle decisions and patient noncompliance. Patients may be more likely to accept treatment for depression if they are aware that it may also improve their glycemic control and lower their risk of other medical complications.

Please consider the following clinical actions:

- Use a standardized depression screening tool such as the PHQ-9 to assess patients with diabetes for depression.
- Educate patients identified as having depression about appropriate treatment options.
- Monitor compliance with an individualized depression treatment plan.
- Encourage patients at risk for type 2 diabetes to modify unhealthy lifestyle behaviors (overeating, lack of physical activity and smoking).


“Depression, Depression Treatment, and Insulin Sensitivity in Adults at Risk for Type 2 Diabetes,” Julie Wagner; Nancy Allen, Leah Swalley, Gail Mellitus, Robin Whittemore in Diabetes Res Clin Pract. 2009;86:96-103. (The Diabetes Journal Club, vol. 6, No. 2)
SuperWell® Disease and Maternity Management Program

To assist members who are pregnant or those diagnosed with certain chronic diseases, we offer the SuperWell Disease and Maternity Management Program.

In addition to maternity management, this program is available for eligible members diagnosed with one or more of the following conditions:

- Asthma
- Diabetes
- Chronic obstructive pulmonary disease
- Heart failure
- Coronary artery disease
- Chronic pain conditions
- Depression

Many of the above conditions co-exist in the same individual; therefore, this program can provide the intensive support necessary to make physician management more effective. Enrollment in the program provides structured education and support by specially trained health coaches. Patients benefit from routine monitoring, education on complication management and the importance of following the prescribed treatment plan.

To enroll a patient into the SuperWell Disease and Maternity Management Program, call us at 800.861.4826.

Medical Policy Highlight

Subject: Tumor Chemosensitivity and Chemoresistance Assays
Policy Number: 2010-B
Initial Effective Date: 04/14/2010

Tumor chemosensitivity and chemoresistance assays (e.g., ChemoFx® Assay, Precision Therapeutics Inc., Pittsburgh, PA) are in vitro assays intended to predict in vivo response of a specific cancer to chemotherapeutic agents. Tumor cells obtained from biopsy or surgical specimens are cultured in vitro with various chemotherapeutic drugs. Tumor cell survival in the presence of specific chemotherapeutic drugs is determined and used to individualize selection of a chemotherapeutic regimen. Chemosensitivity assays are intended to assist in identification of more effective chemotherapeutic agents, while chemoresistance assays may help identify chemotherapeutic agents likely to be ineffective.

Based on our findings, the Company has determined tumor chemosensitivity and chemoresistance assays have not demonstrated equivalence or superiority to currently accepted standard diagnostic techniques. The Company considers tumor chemosensitivity and chemoresistance assays investigational and not eligible for reimbursement.

Please refer to our website for the most current version of Corporate Medical Policy 2010-B.
Speed Is of the Essence

Despite consistent average turnaround times significantly below the industry standard, if your prior approval decision has been delayed, your experience with our medical review process is less than ideal.

In 2009, our average turnaround time for urgent prior approval, expedited appeals and non-expedited appeals reflects our commitment to a prompt response to your request.

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Average Turnaround Time</th>
<th>Industry Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospective Urgent Review</td>
<td>5.8 hours</td>
<td>72 hours</td>
</tr>
<tr>
<td>Expedited Appeals</td>
<td>6.7 hours</td>
<td>72 hours</td>
</tr>
<tr>
<td>Non-Expedited Appeals</td>
<td>13.4 calendar days</td>
<td>30 calendar days</td>
</tr>
</tbody>
</table>

Please consider the information below to ensure that your next review request meets or exceeds our average turnaround time.

**Prior Approval:** Consider using the prior approval form and viewing our medical policies, which are both available on our websites. To improve turnaround time, please provide us with the following:
- Include appropriate CPT, ICD-9 and HCPCS codes
- Submit clinical notes that support the criteria as stated in the medical policy
- Include photos and X-rays (pre and post) for an oral procedure subsequent to an accident
- Submit a written description or operative note when an NOC (not otherwise classified) CPT code is used or when using modifier 22 (increased procedural services)

**Imaging Requests:** Copies of InterQual SmartSheets® are also available on our websites. When calling to request approval for an imaging procedure, please have the following information available:
- Subjective complaints
- Objective findings
- Prior imaging studies
- Specific information addressing conservative treatment (e.g., medication(s), therapy, activity modification), including duration and response to treatment
For Your Information

We remain committed to supplying providers with the programs, information and support needed to ensure the health and well-being of our members and the communities we serve. Access our websites for the following:

Select Providers for:
- Tools & Resources
- Products & Services
- Become a Network Provider
- Health & Wellness

Select Tools & Resources, Care Management,
Clinical Quality for:
- Mission
  - Quality Improvement Program Description
  - Quality Improvement Program Evaluation
  - Technology Assessment Program Description
  - Affirmation Statement
- Accessibility Standards
- Clinical Guidelines
- Medical Necessity Criteria
- Patient Safety
- Discharge Planning

Select Tools & Resources, Clinical Credentialing for:
- Office Site and Medical Record Documentation Standards
- Accessibility Standards
- Sample Forms and Policies

Select Tools & Resources, Contact Us for:
- Contacting the Care Management Department

Select Tools & Resources, Forms for:
- Online Provider Services
- Forms

Select Tools & Resources, Rx Benefit Management for:
- Prescription Formulary
- Pharmaceutical Education
- Prior Authorization
- Clinical Services
- Home Delivery Practices

Select Tools & Resources, Corporate Medical Policies for:
- Medical Policies
- Predetermination
- Investigational Services

Select Tools & Resources, Newsletters & Bulletins for:
- Newsletters
- Bulletins

Select Tools & Resources, Provider Manual for:
- Provider Manual

Select Health & Wellness, Disease and Maternity Management Program for:
- SuperWell Health Management Program

Contact Care Management

Questions about Care Management Processes
The Care Management department is available to address inquiries about utilization management functions, such as inpatient admissions, denials, appeals and referrals (including Behavioral Health services), Monday through Friday, excluding holidays, from 8:15 a.m. to 4:15 p.m. (Eastern). Refer to the numbers on the member’s identification card.

Case Management services are available to help coordinate care, provide information about community services and provide patient education. Please call 800.258.3175 for more information.

Comments and Feedback
Do you have a comment or suggestion you would like to share with us? We are always interested in hearing from providers about our efforts to partner with you to provide the highest quality of care to our members. Contact the Clinical Quality Improvement (CQI) department at 800.586.4523 or write to us at:

Medical Mutual
MZ: 01-5B-7501
2060 East 9th Street
Cleveland, OH 44115
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