In-Network Referral Requirement Eliminated for Medical Mutual Members

Network providers saw a reduction in their administrative tasks when providing services to our Medical Mutual members. Effective January 1, 2008, members in our HMO and POS products no longer need a referral from their primary care physician (PCP) before seeing an in-network doctor or healthcare provider. Members will receive a new Certificate book reflecting this benefit change at the time of their employer's benefit renewal.

As of the effective date, members may seek services from in-network doctors and providers without a referral and the claim for such services will be processed at the referral level benefit.

Members still need a referral from their PCP or specialist for out-of-network services. Information must be provided indicating the necessity of arranging care outside of the network at the time of the request, and we retain the right to approve or deny the out-of-network services.

If you need to submit an out-of-network request, contact the Care Management department at 800/338-4114, option 4. Please be prepared to give the nurse the reason for the out-of-network request.

If you have any questions about this change, please contact your local contracting representative.
Leapfrog Hospital Quality and Safety Survey – An Update

The Leapfrog Group Hospital Quality and Safety Survey was launched in 2001 to provide public reporting of quality and safety practices in U.S. hospitals. The Survey, now in its fourth version, assesses hospital performance based on four quality and safety practices that are proven to reduce preventable medical mistakes and are endorsed by the National Quality Forum (NQF).

Some facilities have been reluctant to complete the Leapfrog survey. It is important to consider the advantages of reporting to Leapfrog, even if you do not meet all of the safety “leaps.” Reporting demonstrates to purchasers and the general public that you are willing to disclose information to the public, review your safety practice and identify opportunities for improvement.

Leapfrog released the 2008 version of the survey on April 1, 2008, and is asking hospitals to complete the updated version. The deadline for 2008 survey submission will be June 30, 2008, for responding hospitals to be included in the first 2008 results, which are scheduled to be released in early July. Leapfrog will continue to publicly report the 2007 survey results through the end of June, when they will be fully replaced with results from 2008 surveys. Thereafter, the 2007 survey results will no longer be used or available.

For information about upcoming changes to the 2008 survey, please see the Leapfrog news item at: leapfroggroup.org/for_hospitals/4717887/whatsnewin2008.

To support the growing trend toward transparency in healthcare, Leapfrog has evolved to include the following:

- The survey is applicable to both urban and rural facilities due to the addition of the National Quality Forum (NQF) Safe Practices Leap (comprising 27 NQF-endorsed practices)
- Following focus group testing the survey data display has been reformatted and worded to be more consumer-friendly
- Addition of a “Transparency Indicator” to give hospitals the opportunity to identify other patient safety and quality reporting initiatives in which they participate in order to provide consumers and purchasers access to even more data about a hospital’s quality and safety
- Addition of a “Never Events” leap
Cardiac Rehabilitation

Promote Secondary Prevention – Cardiac Rehabilitation

The Agency for Health Care Policy and Research, National Heart, Lung and Blood Institute and American Heart Association recommend cardiac rehabilitation/secondary prevention programs for patients diagnosed with coronary heart disease.

Who Can Benefit from Cardiac Rehabilitation?
- Patients with a recent acute myocardial infarction
- Patients who have undergone a cardiac surgical procedure such as:
  - coronary artery bypass graft (CABG)
  - percutaneous transluminal coronary angioplasty (PTCA)
  - angioplasty/stent replacement
  - heart transplantation
- Patients diagnosed with the following conditions:
  - stable chronic heart failure (CHF)
  - peripheral arterial disease with claudication
  - other forms of CVD

Benefits of Cardiac Rehabilitation:
- Improves the quality of life and decreases the risk of death for patients with coronary heart disease.
- Reduces deaths after a heart attack by 25 percent.

Opportunities for Improvement:
- Physician referral rate: Low physician referral rate is a contributing factor for underutilization.
- Patient participation rate: Only 10 to 20 percent of patients who have a heart attack or undergo cardiac bypass surgery attend a medically supervised program.

What Can Be Done?
- Inform patients of the benefits of cardiac rehabilitation before discharge.
- Include comprehensive cardiac rehabilitation in the patient’s discharge plans.
- Make sure that eligible candidates have a physician referral.
- Refer patients with coronary artery disease to our SuperWell Disease and Maternity Management Program by calling 800/861-4826.

Optimize Glycemic Control During Hospitalization

Diabetes complications such as infection, nephropathy and coronary or peripheral vascular disease predispose diabetes patients to hospitalization. Often, inpatient management of hyperglycemia becomes of secondary importance relative to the condition responsible for the admission. However, studies have shown that there is an increased risk of morbidity and mortality if hyperglycemia is left untreated or under treated in any hospitalized patient. Hypoglycemia is an independent risk factor for death in the medical ICU population and merits caution when trying to achieve target blood sugar ranges in critically ill patients.

Hyperglycemia is reportedly related to immunosuppression, platelet aggregation, increased cytokine levels and inflammation, endothelial cell dysfunction and oxidative stress with increase risk of cell and tissue injury.

Inpatient

- Inpatient mortality rises in tandem with increasing plasma glucose levels in both newly hyperglycemic patients and those with diagnosed diabetes.
- Inpatient length of stay is longer in patients with diabetes or hyperglycemia.
- Blood glucose >220 mg/dL on the first postoperative day is associated with significantly higher infection rates.

Target Levels

- The American Diabetes Association has established that blood glucose levels for patients in critical care units should be kept as close to 110 mg/dL as possible.
- In non-critically ill hospitalized patients, pre-meal blood glucose should be <126 mg/dL and random blood glucose levels should be <180-200 mg/dL.
Improving Outcomes

- Prominently display the diagnosis of diabetes in the medical record.
- Patients with fasting blood glucose higher than 126 mg/dL or a random blood sugar higher than 200 mg/dL should have bedside glucose monitoring and development of a treatment plan initiated.
- During the perioperative period, as well as any critical care illness, a diabetic patient should have a continuous intravenous infusion of regular crystalline insulin instead of subcutaneous insulin.
- Involve appropriately trained specialists or specialty teams to manage inpatient diabetes and hyperglycemia to improve outcomes.

Begin discharge planning at least 24 hours before expected discharge, including:
- Establishing plans for follow-up testing and management, particularly in newly diagnosed diabetics.
- Educate the patient and their family/caregivers regarding hypoglycemia, side effects of abnormal blood glucose levels, dietary management and drug administration.
- Ensure adequate patient supplies.

1 Diabetes Care, Vol. 31, Supplement 1, American Diabetes Association: Clinical Practice Recommendations 2008, Standards of Medical Care in Diabetes, Pages 47-55.
3 Diabetes Care, Vol. 31, Supplement 3-4.

Immunizations for New Moms

The CDC now recommends that new moms who show no evidence of immunity or have never been vaccinated should receive the following immunizations prior to discharge from the hospital:

- Rubella
- Varicella
- Tdap (mothers who have never received a dose of Tdap)

If not previously immunized, women 26 and younger should receive the first of three vaccine doses for Human Papillomavirus (HPV) during the routinely scheduled four to six weeks postpartum visit.

1 CDC. Recommended Adult Immunization Schedule United States, October 2006-September 2007.
Back Pain is a common reason for emergency room visits in the United States and represents the fifth most common reason for all physician visits. Back pain is the second most common neurological ailment, affecting an estimated eight out of 10 people at some time in their lives.

Many options are available for diagnosis and management of low-back pain (LBP) and wide variations in clinical approach exist among clinicians. One of the first efforts to encourage consensus among providers was the development of a “Clinical Practice Guideline” by a panel of experts under the auspices of the U.S. Department of Health and Human Services. This guideline, released in 1994, concluded that uncomplicated acute LBP is a benign self-limiting condition for the vast majority of patients. In fact, 90 percent of patients presenting with uncomplicated low back pain, without radiculopathy, recover spontaneously in four weeks. The recommendation of the panel was that conservative treatment is appropriate in most cases of acute uncomplicated LBP.

This approach is supported by more recent evidenced-based studies. In October 2007, The Annals of Internal Medicine published a joint clinical practice guideline developed by the American College of Physicians (ACP) and the American Pain Society (APS), which recommends that:

- Clinicians should conduct a focused history and physical exam to place patients in one of three categories: nonspecific LBP; back pain with radiculopathy; or, back pain associated with a specific spinal cause.
- Clinicians should not routinely obtain diagnostic imaging or testing in patients with nonspecific LBP.
- Clinicians should perform diagnostic imaging and testing for patients with severe LBP or when progressive neurologic deficits are present or serious underlying conditions are suspected.
The American College of Radiology (ACR) “Appropriateness Criteria” mentions that uncomplicated acute LBP does not warrant the use of imaging studies.

The challenge confronting the clinician is identifying that small subset requiring a more detailed evaluation. The ACR identifies the following ‘red flag’ findings that warrant further workup, which include:

- Recent trauma
- Unexplained weight loss or fever
- Immunosuppression
- History of cancer
- Intravenous drug use
- Prolonged use of steroids
- Osteoporosis
- Older than age 70
- Focal neurologic deficits with progressive or disabling symptoms
- Duration greater than six weeks

The focused history and physical exam, conducted by a knowledgeable clinician, remains the “gold standard” for evaluation of acute low back pain. Imaging studies are helpful tools to further assess the small percentage of “red flag” patients.

3 “Low Back Pain Fact Sheet,” NINDS. Publication Date July 2003.
Coding Emergency Department (ED) Services

To facilitate appropriate reimbursement for emergency department (ED) services, it's important to determine if the diagnosis might lead to a question of whether or not the patient presented with a true emergency. Therefore:

- If the diagnosis does not clearly identify an emergent condition, records will be requested by the Company. Records should not be sent in the claim, but with the appeal review request.
- Ensure that the diagnosis indicating an emergent condition or a condition where the patient’s perception is of an emergent condition is the primary diagnosis listed on the claim.
- When reporting the onset date, make sure to indicate the onset of the emergency symptoms and not the underlying cause of the symptoms.

Coding Colonoscopy Screening

The National Committee for Quality Assurance (NCQA) has criteria for determining members in our population who have obtained appropriate preventive health screenings. The codes for colonoscopy screening listed below are a component of the technical specifications required by the Healthcare Effectiveness Data Information Set (HEDIS®) and should be utilized for billing so that you are adequately reimbursed for services rendered and we can accurately measure these important indicators.

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<td>Fecal Occult Blood Test</td>
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<td>G0107, G0328</td>
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<td>G0105, G0121</td>
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Coding PAP Smears

The codes for Papanicolaou screening listed below are a component of HEDIS technical specifications and should be utilized for billing so that services are adequately reimbursed and accurate measurement of this important indicator may be obtained.

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<tr>
<th>Revenue Code</th>
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<tbody>
<tr>
<td>0923</td>
<td>(papanicolaou smear)</td>
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<table>
<thead>
<tr>
<th>International Classification of Diseases (ICD-9 Diagnosis Codes):</th>
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<tr>
<td>V 76.2</td>
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<tr>
<td>V 72.31</td>
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<td>V 72.31 plus V 76.47</td>
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Coding Procedures for Electronic Inpatient Acute Care

ReviewLink allows providers the opportunity to submit electronic clinical reviews including detailed clinical comments, diagnosis codes and procedure codes. The diagnosis code(s) and clinical comments are required elements, but procedure codes are optional. Although a procedure code is not required, entering an appropriate CPT code could increase the speed of your review outcome. CP codes should be entered with the most complex procedure listed first.
Pertussis is an acute, infectious cough illness that remains endemic in the United States despite longstanding routine childhood pertussis vaccination. Immunity to pertussis wanes approximately five to 10 years after completion of childhood vaccination, leaving adolescents and adults susceptible to pertussis. Since the 1980s, the number of reported pertussis cases has steadily increased, especially among adolescents and adults.

Historically, adults ages 19 through 64 were advised to obtain a tetanus and diphtheria toxoids (Td) booster at least every 10 years. In order to protect the vaccinated adult against pertussis and to reduce the reservoir of pertussis in the population at large, the Advisory Committee on Immunization Practices (ACIP) recommends replacement of at least one of the boosters of Td with booster of tetanus, diphtheria and pertussis (Tdap). Administration of Tdap will potentially decrease exposure of persons at increased risk of complications (e.g. infants) and reduce the cost and disruption of pertussis in healthcare facilities.

The ACIP recommends that:

- Adults between ages 19 and 64 receive a single dose of Tdap to replace Td for booster immunization if they received their last dose of Td ten or more years earlier and they have not previously received Tdap.

- Adults who have or who anticipate having close contact with infants less than 12 months (e.g., healthcare personnel, grandparents ages 65 and older and childcare providers) should receive a single dose of Tdap to reduce risk of transmitting pertussis. An interval as short as two years from the last Td is suggested. Women who have not previously received Tdap should receive it in the immediate postpartum period.

- Healthcare personnel who work in hospitals or ambulatory care settings and have direct patient contact should receive a single dose of Tdap, if not previously received. An interval as short as two years from the last Td is suggested. This recommendation is supported by the Healthcare Infection Control Practices Advisory Committee (HICPAC).

In recognition of the confusion caused by the terms precertification, preauthorization and predetermination, we are in the process of deleting these terms from our provider communications and will use the term **prior approval** instead. The term **prior approval** will be utilized for all Corporate Medical Policies, reimbursement remark codes, Care Management letters, provider manuals and various other provider communications from the Company.

**ReviewLink Expands Scope**

Our current Web-based application for electronically submitting medical necessity review information, ReviewLink, allows providers a broad range of reviews that can be processed. Hospitals are able to submit reviews for medical-surgical, hospital-based physical rehabilitation and skilled nursing admissions. Access to Smartsheets and the ability to submit requests for outpatient imaging services is also available. The system is user friendly, HIPAA compliant and provides around the clock ability to submit prior approval or concurrent clinical information.

Utilization of *ReviewLink*, our electronic prior approval application, is being extended to community-based and facility-based long term acute care (LTAC) providers and to community-based skilled nursing and acute inpatient rehabilitation facilities.

Access to *ReviewLink* allows our providers the flexibility to submit requests for inpatient admissions and concurrent stays online 24 hours a day, seven days per week.

If your facility or unit would like to learn more about this opportunity, please contact Robin Bender at 800/338-4114, option 6, extension 37198.

**It’s Now Called “Prior Approval”**

In recognition of the confusion caused by the terms precertification, preauthorization and predetermination, we are in the process of deleting these terms from our provider communications and will use the term **prior approval** instead. The term **prior approval** will be utilized for all Corporate Medical Policies, reimbursement remark codes, Care Management letters, provider manuals and various other provider communications from the Company.
Electronic Certification for Behavioral Health Reviews

The Behavioral Health department will soon implement ReviewLink, a Web-based process, for inpatient medical necessity review. The implementation is being targeted for fourth quarter of 2008. ReviewLink enables facilities to submit, via the Web, demographic and clinical review information in user-friendly, HIPAA-secure format.

This method eliminates the need for waiting on the phone and allows for around the clock ability to submit the certification information.

ReviewLink is in place and being utilized to submit a broad range of medical/surgical reviews so many contracting providers may already be familiar with utilizing the ReviewLink system. If you have questions about the ReviewLink system, contact Kristen Shordt at 419/473-7272.

In the near future you will be contacted or will receive information regarding security access, training and implementation.