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Winter

Provider News

Please share our news.

This newsletter is designed to communicate pertinent health plan information to contracted health care administrative staff as well as medical staff. So, if you are the office person receiving our newsletter, PLEASE share this newsletter with everyone in your office. If you would like us to send you additional paper copies or an electronic copy to make routing easier, please contact the newsletter editor at 920-617-6305 or email: GBNetworkDevelopmentDept@AriseHealthPlan.com

TTY/TDD users may contact us at 920-347-9390 (local) or 1-888-332-0144 (toll free).

HMO/POS Commercial Products

Utilization Management Timeliness Standards

Arise Health Plan (AHP) adheres to the timeliness standards specified by NCQA, the National Committee for Quality Assurance.

-For non-urgent pre-service decisions, AHP makes decisions within 15 calendar days of receipt of the request.

-For urgent pre-service decisions, AHP makes decisions within 72 hours of receipt of the request.

-For urgent concurrent review, the AHP makes decisions within 24 hours of receipt of the request.

-For post service decisions, the organization makes decisions within 30 calendar days of receipt of the request.

These timeframes are dependent on the health plan receiving the necessary clinical information at the time of receipt of a request. Pre-service authorization requests and clinical information can be faxed (920) 490-6943 or mailed.

AHP may request additional medical records if the information submitted to make a determination. AHP has 15 days to make a pre-service authorization decision. In the case of a retrospective review, AHP has 30 days to make a decision.

If AHP cannot make a decision by these deadlines, we notify the affected members and care provider(s) that an extension is necessary. We also indicate the date by which we expect to make a decision.

Arise Health Plan must abide by these standards as part of maintaining our accreditation with NCQA. We consistently strive to exceed these standards and meet the needs of our member

Disease Management Programs

Arise Health Plan (AHP) is excited to announce its new disease management programs designed for patients living with asthma and low back pain. AHP offers these programs at no additional cost to its members.

Highly educated and trained case managers will partner with your patient to help support, educate, and facilitate adherence to the care plan and compliance with medication. By using comprehensive assessment questionnaires, the case manager identifies problems and sets realistic goals with the patient. Together they implement interventions to achieve these goals. All of these steps are communicated to you and your staff every step of the way. The main goal is to provide individualized support to your patient to achieve the best results and control of their chronic conditions. The AHP disease management case managers are available Monday through Friday during business hours. For any questions or concerns please contact a disease management case manager at (800) 333-5003 Ext 64177 or Email at diseasemanagement@arisehealthplan.com.

Provider Manual Update

The Provider Manual will be updated for an effective date of January 1, 2015, and is currently available on our website. To view the updated manual, go to www.wecareforwisconsin.com

Grievance and Appeals

A grievance is any dissatisfaction with the administration, claims practices, or provision of services by Arise Health Plan that is expressed in writing to Arise Health Plan, by or on behalf of, a covered person. The Grievance Committee is comprised of Arise Health Plan representatives, including a clinical representative, and an enrollee. Any covered person who files a grievance will be notified of their right to appear in person before the Grievance Committee. The covered person, or their authorized representative, may present written or oral information and ask any questions relating to the grievance. Arise Health Plan will send the covered person written notice of the time and place the covered person may appear before the Grievance Committee at least seven calendar days prior to the appearance date. Following a thorough review of the case, the grievance committee votes on the resolution. A resolution letter is sent to the member within ten calendar days.

Affirmative Statement on Incentives

Utilization Management (UM) decision making at Arise Health Plan is based only on appropriateness of care and service and existence of coverage. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Coordination of Care

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment and referral. We would like to take this opportunity to stress the importance of communicating with the member's other health care practitioners. This includes primary care physicians (PCPs) and medical specialists, as well as behavioral health practitioners.

Coordination of care is especially important for members with high utilization of general medical services and those referred to a behavioral health specialist by another health care practitioner. We urge all practitioners to obtain the appropriate permission from these members to coordinate care between behavioral health and other health care practitioners at the time treatment begins.
We expect all health care practitioners to:

- Discuss with the member the importance of communicating with other treating practitioners
- Obtain a signed release from the member and file a copy in the medical record
- Document in the medical record if the member refuses to sign a release
- Document in the medical record if you request a consultation
- If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner
- Document evidence of clinical feedback (i.e., consultation report) that includes, but is not limited to:
  – Diagnosis
  – Treatment plan
  – Referrals
  – Psychopharmacological medication (as applicable)

Availability of Medical Policy Guidelines

Physicians and other practitioners may obtain the medical policy guidelines used for making medical coverage determinations for an Arise Health Plan member under their care. If you have received a determination and would like to review the medical policy guidelines used in that determination, you may contact us.

To obtain medical policy guidelines for a specific subject through the Medical Management Department of Arise Health Plan, submit your request via telephone, fax, or in writing to **Arise Health Plan, Medical Management Department, P.O. Box 11625, Green Bay, WI 54307-1625, Telephone (920) 490-6900 or 888-711-1444 toll-free, Fax (920) 490-6943.** If applicable, please include the patient name and member number along with the subject (procedure/service/treatment) for which you are requesting the medical policy guidelines.

The medical policy guidelines are an informational resource and not an authorization, an explanation of benefits, or a contract to provide benefits. Receipt of benefits is subject to satisfaction of all terms and conditions of the member's contract in effect at the time services are rendered. Medical technology is constantly changing, and we reserve the right to review and update our medical policy guidelines as necessary.

We hope that by providing the specific medical policy guidelines upon request, you may better understand the basis for a decision. Our medical policy guidelines are based on sound medical and clinical evidence and adopted with the involvement of appropriate medical specialists. If you have comments or suggestion regarding any specific guideline, these may be forwarded in writing to **Arise Health Plan, Medical Management Department, P.O. Box 11625, Green Bay, WI 54307-1625.**

Denial Notices

Physicians and other practitioners may contact a physician, appropriate behavioral health, or pharmacist reviewer to discuss medical necessity denial decisions for an Arise Health Plan member under their care. If you have received a denial notice and would like to discuss that denial determination and review the medical policy guidelines used, you may contact the Medical Management Department of Arise Health Plan via telephone, fax, or in writing:

Arise Health Plan Medical Management Dept.
P.O. Box 11625
Green Bay, WI 54307-1625
(920) 490-6900 or toll free (888) 711-1444
Fax (920) 490-6943

Evidence Based Medical Decision Making Tools

Coverage decisions made by Arise Health Plan are based upon evidence-based medical resources. Following is a list and description of some, but not all, of the resources used by Arise.

Hayes, Inc.
Hayes, Inc. is an independent health technology research and consulting company dedicated to promoting better health outcomes. Hayes performs unbiased, evidence-based healthcare technology assessments of the safety and efficacy of new, emerging, and controversial health technologies and evaluates the impact of these technologies on healthcare quality, utilization, and cost.

Hayes Health Technology Assessment (HTA) reports provide critical appraisals of the published evidence regarding the safety, efficacy, and clinical impact of a particular healthcare technology (eg. medical device, pharmaceutical or therapeutic intervention, diagnostic or screening test, or preventive strategy). Where applicable, the technology is compared with conventional standards of care and other alternate or competing technologies.

MCG (formerly Milliman Care Guidelines)
MCG® are evidence-based clinical guidelines that span the continuum of care, including chronic care and behavioral health management. The Milliman team of doctors, nurses, and other clinicians build evidence-based authorization criteria, care pathways, and other care management tools.
MCG enables payers, care providers, and facilities to efficiently and consistently make care decisions grounded in rigorous, up-to-date research.

National Guideline Clearinghouse
The National Guideline Clearinghouse (NGC) is an initiative of the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. NGC was originally created by AHRQ in partnership with the American Medical Association and the American Association of Health Plans.

National Comprehensive Cancer Network
The National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology address 97 percent of all patients with cancer. NCCN Guidelines™ are developed through an explicit review of the evidence integrated with expert medical judgment by multidisciplinary panels from NCCN member institutions. NCCN Guidelines Panels address cancer detection, prevention and risk reduction, workup and diagnosis, treatment and supportive care.

Pre-Service Authorization FAQs

What Is a Pre-service Authorization?
A pre-service authorization is the process of receiving written approval from Arise Health Plan for certain services, prior to them being rendered. The pre-service authorization is a written form submitted by a participating practitioner. Services are subject to all plan provisions including, but not limited to, medical necessity and plan exclusions.

When Is a Pre-service Authorization Needed?
Pre-service authorization is required for all nonparticipating practitioners/providers and tertiary care specialists/our facilities. Pre-service authorization is required for specialized services including:

- Elective Inpatient stays in a Hospital or Skilled Nursing Facility (Nursing Home)
- Transplants
- Durable Medical Equipment with a purchase price greater than $1,000 or rental costing more than $750 a month and all CPAP purchases and rentals
- Home infusion
- Prosthetics over $5,000
- New medical or biomedical technology
- New surgical methods or techniques
- Non- Emergency Ambulance Transportation
- Genetic Studies, and Testing
- Pain Management procedures
- Services performed as part of a research study or clinical trial
- Varicose vein treatment, blepharoplasty or any other procedure that may be considered cosmetic
- Sleep studies and recommended aftercare
- Neuropsychological testing
- Spinal surgery
- Certain pediatric vision services
- High dollar imaging
- Drugs that require prior authorization

Before seeking medical services, members should call Arise Health Plan **Member Services at (920) 490-6900 or toll-free (888) 711-1444**, to verify the pre-service authorization request has been approved.

Services that Do Not Require Pre-Service Authorization

- Services performed by a participating Practitioner, including a participating provider who specializes in obstetrics or gynecology, unless for those services noted above.
- Emergency care or urgent care, at an emergency or urgent care facility.
- Covered radiologist, pathologist, and anesthesiologist services at a participating facility.

Whose Responsibility Is It To Obtain the Pre-service Authorization?

- It is the member's responsibility to ensure the pre-service authorization request is submitted and approved by Arise Health Plan prior to receiving services. Pre-service authorization forms are available to print on Arise Health Plan's website **www.WeCareForWisconsin.com.**

Clinical Practice Guidelines

Clinical Practice Guidelines are designed to assist physicians by providing an analytical framework for the evaluation and treatment of patients with specific clinical circumstances. They are not intended to replace professional judgment or to establish a protocol for patients with a particular condition. A guideline will rarely establish the only approach to a problem.
Practice guidelines have a sound scientific basis, such as clinical literature and expert consensus. The selected guidelines are from nationally recognized organizations and have been reviewed by Advisory Committees.

Practice guidelines are not intended to determine plan benefits and do not reflect coverage. Benefit coverage varies by group and should be verified prior to services being rendered.

As a condition of accreditation, The National Committee for Quality Assurance (NCQA), which is the accrediting organization for managed care plans, requires the adoption of Clinical Practice Guidelines. In addition, guidelines are helpful in demonstrating the quality of care we provide to those who purchase our services. Clinical Practice Guidelines adopted by Arise Health Plan may easily be accessed by visiting the Arise Health Plan web site at www.WeCareForWisconsin.com and clicking the Policies tab.

Another valuable resource for accessing nationally recognized and supported Clinical Practice Guidelines is the National Guideline Clearinghouse produced by the Agency for Healthcare Research and Quality (AHRQ). This site is available at www.guideline.gov/index.aspx.

Currently fourteen clinical practice guidelines for acute and chronic medical care have been adopted, two of which relate to behavioral health and two guidelines for general preventative health services, adult and pediatric. The selected guidelines are from nationally recognized organizations using evidence-based outcomes:

- Adult depression in primary care
- Adult preventive care
- Asthma
- Attention deficit hyperactivity disorder
- Controlling blood pressure
- Diabetes mellitus
- Diagnosis and management of chronic heart failure in the adult
- Diagnosis and treatment of low back pain
- Diagnosis and treatment of stable chronic obstructive pulmonary disease
- Healthy lifestyles
- Pediatric preventive care
- Prevention, assessment and treatment of child and adolescent overweight and obesity
- Secondary prevention for patients with coronary and other atherosclerotic vascular disease
- Prenatal Care

Arise Health Plan's
Quality Improvement Program Measures Up

Arise Health Plan (AHP) annually reviews and evaluates our Quality Improvement (QI) Program and develops a QI Work Plan that helps us to continually improve the quality of care given by our contracted providers. AHP's QI program & work plan includes both clinical and quality service initiatives. To evaluate program effectiveness AHP uses Healthcare Effectiveness Data & Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers Systems (CAHPS®). HEDIS® is developed and maintained by the National Committee for Quality Assurance (NCQA), a non-profit health care quality organization. Our goal is to exceed the 90th percentile nationally based on NCQA's Quality Compass®. Many HEDIS® and CAHPS® measures exceeded the national average this year. Detailed results of the HEDIS® and CAHPS® measures can be viewed at www.wecareforwisconsin.com/quality.

Even though many of our HEDIS scores exceed the national average, we still have room for improvement. For example, diabetic measures such as kidney monitoring and retinal eye exams declined over the past year, as did appropriate testing for children with pharyngitis. Arise Health Plan exceeded the national percentile on the majority of our CAHPS® measures of member satisfaction. We improved regarding members rating their personal doctor's explanation as easy to understand, showing respect for what the member had to say, and spending enough time with the member. We would like to thank our practitioners for the hard work and dedication that they provide for our members.

A printed copy of this information is available upon request.
[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)
[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)
[3] The source for data contacted in this publication is Quality Compass® and is used with the permission of the National Committee for Quality Assurance (NCQA). Any analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA.

Provider Directory

For the convenience of our providers and members, a provider directory is available on our website at: http://www.wecareforwisconsin.com/members/find_a_doctor/ then enter the group number. The provider directory can be printed or accessed on the website.

If the provider or facility information listed is not correct, we request that the Provider Update Datasheet be completed and return to Arise Network Development. This form is available on our website at: http://www.wecareforwisconsin.com/providers/forms and select the Provider Update Datasheet.

Prescription Drug Program Information

Information regarding Arise Health Plan's Prescription Drug Program can be found on our website. Elements described include how the formulary is developed and maintained, the pre-authorization program for selected drugs, generic substitution, and appropriate-use features like drug interaction monitoring and quantity thresholds.

If you would like a copy of this information, please contact **Member Services at (888) 711-1444**.

Practitioner Rights Pertaining to Credentialing

Credentialing of practitioners is performed by the Arise Health Plan Credentialing Department upon initial contracting of practitioners, and every three years thereafter. Practitioners undergoing the credentialing process have the following rights:

- You have the right, upon request, to be informed of the status of your application at any time and to review a summary of information obtained by the Credentialing Department for the purpose of evaluating your application, excluding confidential peer references and evaluations or information that is peer review protected.
- You will be promptly notified of information that varies significantly from the information you have provided and be given the opportunity to submit updated/additional documentation or corrections. The Correction of erroneous information must be done, in writing, within ten (10) days of being notified of the varying information by the Credentialing Department. The Credentialing Department is not obligated to reveal the source of information if disclosure is prohibited by law.
- You will be notified of the Credentials Committee decision regarding your application via written letter within 60 calendar days of the committee's credentialing or re-credentialing decision.

If you have any questions regarding the Arise Health Plan credentialing process, please contact the **Credentialing Department at (920) 490-6952.**

Member Rights and Responsibilities

Health Plan Member Rights

- You have the right to be treated with respect and recognition of your dignity and right to privacy.
- You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- You have the right to participate with practitioners in making decisions about your health care.
- You have the right to receive information about us, our services, and our network of health care practitioners and providers as well as your rights and responsibilities.
- You have the right to voice complaints or appeals about us or the health care coverage we provide.
- You have the right to make recommendations regarding the member rights and responsibilities policies.

Health Plan Member Responsibilities

- You have the responsibility to supply information (to the extent possible) that our practitioners and providers need in order to provide care and that we need in order to provide coverage.
- You have the responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- You have the responsibility to follow the treatment plan and instructions for care that have been agreed on with your practitioners.

Utilization Review Matrix 2015 – Arise Health Plan

The matrix below contains all of the CPT-4 codes for which National Imaging Associates (NIA) authorizes on behalf of Arise Health Plan. This matrix is designed to assist in the resolution of claims adjudication and claims questions related to those services authorized by NIA. If an exam is billed under any one of the given codes for that grouping and a valid authorization number has been issued within the date of service validity period, the charge for any of the codes should be allowed.

If a family of CPT codes is not listed in this matrix, an exact match is required between the authorized CPT code and the billed CPT code. If the exact match does not occur, the charge should be adjudicated accordingly.

Please Note: Services rendered in an Emergency Room, Observation Room, Surgery Center or Hospital Inpatient settings are not managed by NIA.

Authorized CPT Code	Description	Allowable Billed Groupings
70336	MRI Temporomandibular Joint	70336
70450	CT Head/Brain	70450, 70460, 70470
70480	CT Orbit	70480, 70481, 70482
70486	CT Maxillofacial/Sinus	70486, 70487, 70488, 76380
70490	CT Soft Tissue Neck	70490, 70491, 70492
70496	CT Angiography, Head	70496
70498	CT Angiography, Neck	70498
70540	MRI Orbit, Face, and/or Neck	70540, 70542, 70543
70551	MRI Internal Auditory Canal	70551, 70552, 70553, 70540, 70542, 70543
70544	MRA Head	70544, 70545, 70546
70547	MRA Neck	70547, 70548, 70549
70551	MRI Brain	70551, 70552, 70553
70554	Functional MRI Brain	70554, 70555
71250	CT Chest	71250, 71260, 71270, S8032
71275	CT Angiography, Chest (non coronary)	71275
71550	MRI Chest	71550, 71551, 71552
71555	MRA Chest (excluding myocardium)	71555
72125	CT Cervical Spine	72125, 72126, 72127
72128	CT Thoracic Spine	72128, 72129, 72130
72131	CT Lumbar Spine	72131, 72132, 72133
72141	MRI Cervical Spine	72141, 72142, 72156
72146	MRI Thoracic Spine	72146, 72147, 72157
72148	MRI Lumbar Spine	72148, 72149, 72158
72159	MRA Spinal Canal	72159
72191	CT Angiography, Pelvis	72191
72192	CT Pelvis	72192, 72193, 72194
72196	MRI Pelvis	72195, 72196, 72197
72198	MRA Pelvis	72198
73200	CT Upper Extremity	73200, 73201, 73202
73206	CT Angiography, Upper Extremity	73206
73220	MRI Upper Extremity, other than Joint	73218, 73219, 73220
73221	MRI Upper Extremity Joint	73221, 73222, 73223
73225	MRA Upper Extremity	73225
73700	CT Lower Extremity	73700, 73701, 73702
73706	CT Angiography, Lower Extremity	73706
73720	MRI Lower Extremity	73718, 73719, 73720, 73721, 73722, 73723
73721	MRI Hip	72195, 72196, 72197, 73721, 73722, 73723
73725	MRA Lower Extremity	73725
74150	CT Abdomen	74150, 74160, 74170
74174	CT Angiography, Abdomen and Pelvis	74174

74175	CT Angiography, Abdomen	74175
74176	CT Abdomen and Pelvis Combination	74176, 74177, 74178
74181	MRI Abdomen	74181, 74182, 74183, S8037
74185	MRA Abdomen	74185
74261	Diagnostic CT Colonoscopy (Virtual Colonoscopy, CT Colonography)	74261, 74262
74263	Screening CT Colonoscopy (Virtual Colonoscopy, CT Colonography)	74263
75557	MRI Heart	75557, 75559, 75561, 75563, +75565
75572	CT Heart	75572
75573	CT Heart congenital studies, non-coronary arteries	75573
75574	CTA coronary arteries (CCTA)	75574
75635	CT Angiography, Abdominal Arteries	75635
76380	Follow Up, Limited or Localized CT	76380, 70486, 70487, 70488
76390	MR Spectroscopy	76390
77058	MRI Breast	77058, 77059
77084	MRI Bone Marrow	77084
78451	Myocardial Perfusion Imaging – Nuclear Cardiology Study	78451, 78452, 78453, 78454, 78466, 78468, 78469, 78481, 78483, 78499
78459	PET Scan, Heart	78459, 78491, 78492
78472	Muga Scan	78472, 78473, 78494, +78496
78608	PET Scan, Brain	78608, 78609
78813	PET Scan	78811, 78812, 78813, 78814, 78815, 78816
78816	PET Scan with concurrently acquired CT for attenuation correction and anatomic, localization.	78811, 78812, 78813, 78814, 78815, 78816
G0235	PET imaging, any site, not otherwise specified	G0235
S8032	Low Dose CT For Lung Cancer Screening	S8032
S8037	MR Cholangiopancreatography	S8037, 74181, 74182, 74183
0042T	Cerebral Perfusion Analysis CT	0042T

+ codes (add on codes) do not require separate authorization and are to be used in conjunction with approved primary code for the service rendered.

Advance Directives — Preparing Members and Families for Difficult Decision-Making

It’s critical to discuss the importance of advance directives — either living wills or durable powers of attorney — with members in your care. Taking this important step ensures their wishes are followed in the event of debilitating injuries or illnesses.

Remember…

- All members over the age of 18 have the right to an advance directive.
- You may not condition the provision of care or otherwise discriminate against a member based on whether or not he or she has executed an advance directive.
- Maintain information on the member’s advance directive in the medical record — we audit for this information when conducting medical record reviews.
- Check our provider website for links to templates for living wills and durable powers of attorney — some states require use of a state-produced form.

Living will —
Written instruction stating the kind of medical care a member wants or does not want if he or she is unable to make such decisions once becoming sick or injured

Durable power of attorney —
Written, signed, dated and witnessed statement naming another person to act on behalf of the member if that member is unable to make such decisions once becoming sick or injured.

More than a Score: Working Together to Achieve Better Health Outcomes While Meeting HEDIS Measures

We know you've heard of HEDIS, established by the National Committee for Quality Assurance (NCQA). We send letters and reminders about members overdue for services related to HEDIS measures — you might even be eligible for incentive payments when helping members get these important services.

But it's not just about the scores. It's about the woman whose Pap smear led to early detection and treatment of her cervical cancer. Or the toddler who didn't get whooping cough during last year's outbreak because he got his shot on time. Or the grandfather who kept up with cholesterol screenings and avoided another heart attack.

We thank you for giving our members the highest quality care possible. Working together to meet these benchmarks, we have the best chance of improving our members' health outcomes and, ultimately, their quality of life. We would like to expand our collaboration efforts in supporting provider's offices as they outreach patients. Please have someone from your office or Quality Department contact the Arise Quality Department via email at gbqualitydept@arisehealthplan.com to pursue collaborative opportunities.

Why is HEDIS® important to physicians?
HEDIS® measures track a health plan's and physician's ability to manage health outcomes. Generally, strong HEDIS® performance reflects enhanced quality of care. With proactive population management, physicians can monitor care — improving quality while reducing costs.

Why is the Adult BMI Assessment important?
Being overweight or obese significantly increases an individual's risk for other health problems, such as coronary heart disease, high blood pressure, stroke, type 2 diabetes, certain cancers, arthritis, and more.
- National Heart, Lung, and Blood Institute (NHLBI)

How does HEDIS® define Adult BMI Assessment?
The percentage of commercial, Medicaid, and Medicare Advantage HMO and PPO members ages 18 through 74 who had an outpatient visit and whose Body Mass Index (BMI) was documented during the measurement year or prior year.

Calculating BMI
No Electronic Medical Record? Use the NHLBI mobile phone app or online calculator, which is available at *www.nhlbi.nih.gov/guidelines/obesity/BMI/ bmicalc.htm*.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

HEDIS® definition
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.

- BMI percentile documentation.
- Counseling for nutrition.
- Counseling for physical activity.

Please refer to our clinical guidelines relating to the management of childhood obesity, located on our website.

Avoidance of antibiotic treatment in adults with AAB – Highlighting HEDIS®: and appropriate treatment for children with URI

HEDIS® definitions

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB): The percentage of Commercial and Medicaid members 18 to 64 years with a diagnosis of AAB who were not dispensed an antibiotic prescription within three days of visit date.

Appropriate Treatment for Children with upper respiratory infection (URI): The percentage of children 3 months to 18 years who were given a diagnosis of URI and were not dispensed an antibiotic prescription within three days of visit date.

Educational resources
Educating your patients on the proper usage of antibiotics and the long-term risks of antibiotic resistance is critical to improving these measures. To help, here are links to resources from the Centers for Disease Control and Prevention (CDC) for you and your patients:

For providers: *www.cdc.gov/getsmart/campaign-materials/ treatment-guidelines.html*
For patients: *www.cdc.gov/getsmart/specific-groups/everyone.html*

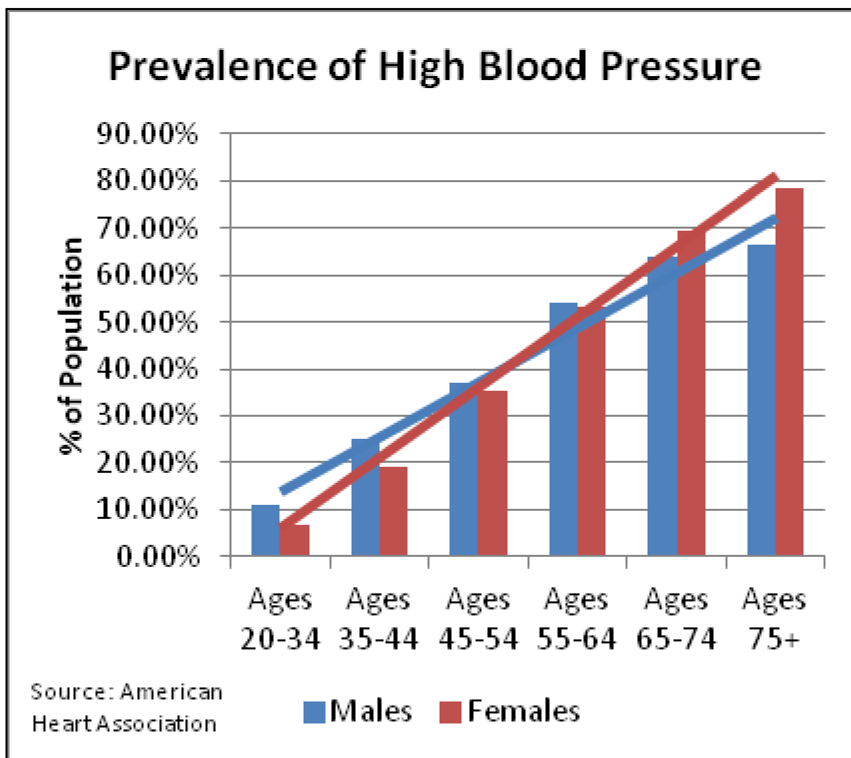
Quick tips for improvement

- **The 3-Day Rule:** Follow up with patients three days after the initial visit to discuss treatment options if symptom relief has not occurred.
- **The Poster Board Pledge:** Recent studies have shown that displaying poster-sized commitment letters in exam rooms to avoid inappropriate antibiotic prescribing was a simple, low-cost, and effective method for improvement – *JAMA Internal Medicine*
- **Coding 101:** If your patient has comorbidities, bacterial infections, or competing diagnoses, the standard codes for AAB and URI may not be applicable.

1 *The National Committee for Quality Assurance (NCQA) is the most widely recognized accreditation program in the U.S.*
2 *The Healthcare Effectiveness Data and Information Set (HEDIS) is an NCQA tool used by more than 90 percent of U.S. health plans to measure performance on important dimensions of care.*

Controlling high blood pressure

HEDIS® definition Controlling High Blood Pressure (CBP): The percentage of commercial and Medicare members ages 18 – 85 who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90) during the measurement year.



Quick tips for improvement

- Measure a patient's blood pressure at the beginning and end of each visit, making sure to record the lower value.
- Provide patients with educational resources from the Centers for Disease Control and Prevention: *www.cdc.gov/bloodpressure/materials_for_patients.htm*.

Use of Appropriate Medications for People with Asthma

HEDIS® definition

Use of Appropriate Medications for People with Asthma: The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

Medication Management for People with Asthma

HEDIS® definition

Medication Management for People with Asthma: 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:

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

Use of spirometry testing in the assessment and diagnosis of COPD

HEDIS® definition

Use of spirometry testing in the assessment and diagnosis of COPD: The percentage of commercial and Medicare members ages 40 and older with a new diagnosis of chronic obstructive pulmonary disease (COPD) or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.

Note: A period of two years with no claims/encounters containing any diagnosis of COPD is needed for a member to be considered newly diagnosed. For these members, HEDIS® is searching for at least one claim/encounter for spirometry testing within the last two years to confirm the diagnosis.

Colorectal cancer screening

HEDIS® definition

Colorectal cancer screening: The percentage of commercial and Medicare members ages 50 – 75 who had appropriate screening for colorectal cancer during the measurement year.
Any of the following tests meets the criteria:

fecal occult blood test – guaiac (gFOBT) or immunochemical (iFOBT) during the measurement year;
flexible sigmoidoscopy during the measurement year or four years prior to the measurement year;
colonoscopy during the measurement year or nine years prior to the measurement year.

Note: Digital rectal exams do not count as evidence of colorectal cancer screening because they are not specific or comprehensive enough to screen for colorectal cancer. Additionally, members who had either colorectal cancer or a total colectomy at any time in their history are excluded.

The importance of screening

"Colorectal cancer is the second leading cause of cancer-related deaths in the U.S. It places significant economic burden on society: treatment costs over $6.5 billion per year. Unlike other screening tests that only detect disease, some methods of screening can detect premalignant polyps and guide their removal, which in theory can prevent cancer from developing." — *NCQA, HEDIS 2013 V1*

Persistence of beta-blocker treatment after a heart attack

HEDIS® definition

Persistence of beta-blocker treatment after a heart attack: The percentage of members ages 18 and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of an acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.

Importance of beta-blocker therapy

According to results of large-scale clinical trials, beta-blockers consistently reduce subsequent coronary events, cardiovascular mortality, and all-cause mortality by 20 – 30 percent after an AMI when taken indefinitely. Literature suggests that adherence to beta-blockers declines significantly within the first year. About half of AMI survivors who are eligible for beta-blocker therapy do not receive it. Test data reveal significant underutilization of beta-blockers 180 days post-AMI. There is evidence suggesting that around 2,900 – 5,000 lives are lost in the United States in the first year following an AMI, from the under-prescribing of beta-blockers. — NCQA, HEDIS 2013 V1

Use of imaging studies for low back pain

HEDIS® definition

Use of imaging studies for low back pain: The percentage of commercial members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.
Note: This measure is reported as an inverted rate (1 – [numerator/eligible population]). A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

The importance of imaging studies for low back pain

Low back pain is a pervasive problem that affects two-thirds of adults at some time in their lives. It ranks among the top ten reasons for patient visits to internists and is the most common and expensive reason for work disability in the U.S. For most individuals, back pain quickly improves. Nevertheless, approximately 15 percent of the U.S. population reports having frequent low back pain that lasted for at least two weeks during the previous year. Persistent pain that lasts beyond 3 to 6 months occurs in only 5 percent to 10 percent of patients with low back pain. According to the American College of Radiology, uncomplicated low back pain is a benign, self-limited condition that does not warrant imaging studies. The majority of patients are back to their usual activities in 30 days.
— *NCQA, HEDIS 2013 V1*

A Quick Guide to Tests for People with Diabetes

How Often	What	Why
Every doctor visit	Blood pressure check	To detect high blood pressure
	Quick foot exam	To check for foot sores
Every three months	A1c blood test	To measure average blood glucose level over the past few months
At least twice a year	Dental checkup	To detect gum and mouth disease
At least once a year	Blood lipids test	To measure cholesterol and triglyceride levels
	Complete foot exam	To check for problems with foot circulation and nerves
	Dilated eye exam	To detect eye disease
	Kidney function test (blood and urine)	To detect kidney disease, such as nephropathy

Screening patients with Chronic Conditions for Depression

For millions of people, chronic illnesses and depression are facts of life. Many people with these illnesses become depressed. In fact, depression is one of the most common complications of chronic illness. It's estimated that up to one-third of people with a serious medical condition have symptoms of depression.
It's not hard to see the cause and effect relationship between chronic illness and depression. Serious illness can cause tremendous life changes and limit your mobility and independence. A chronic illness can make it impossible to do the things you enjoy, and it can eat away at your self-confidence and a sense of hope in the future. No surprises, then, that people with chronic illness often feel despair and sadness. In some cases, the physical effects of the condition itself or the side effects of medication lead to depression, too. Providers that care for patients with chronic illness are encouraged to screen their patients annually for depression.

What Chronic Conditions Trigger Depression?
Although any illness can trigger depressed feelings, the risk of chronic illness and depression gets higher with the severity of the illness and the level of life disruption it causes. The risk of depression is generally 10-25% for women and 5-12% for men. However, people with a chronic illness face a much higher risk -- between 25-33%. Risk is especially high in someone who has a history of depression.
Depression caused by chronic disease often makes the condition worse, especially if the illness causes pain and fatigue or it limits a person's ability to interact with others. Depression can intensify pain, as well as fatigue and sluggishness.
Research on chronic illnesses and depression indicates that depression rates are high among patients with chronic conditions:

- Heart attack: 40%-65% experience depression
- Coronary artery disease (without heart attack): 18%-20% experience depression
- Parkinson's disease: 40% experience depression
- Multiple sclerosis: 40% experience depression
- Stroke: 10%-27% experience depression
- Cancer: 25% experience depression
- Diabetes: 25% experience depression
- Chronic pain syndrome: 30%-54% experience depression

Treatment Options
Depression is treated much the same way for someone who is chronically ill as someone who isn't. Early diagnosis and treatment can ease distress along with the risk of complications and suicide. Many times, depression treatment can improve your overall medical condition, a better quality of life, and a greater likelihood of sticking to a long-term treatment plan.

Clinical Practice Guideline for Providers: Management of Hyperlipidemia in Patients with Cardiovascular Disease Screening Recommendations

(Source: USPSTF, 2008)
The United States Preventive Services Task Force (USPSTF) recommends the following for screening of lipid disorders:

- Screening **men aged 35 and older** (Grade A Recommendation).
- Screening **men aged 20 to 35** if they are at increased risk for coronary heart disease (Grade

B).
- Screening **women aged 45 and older** if they are at increased risk for coronary heart disease (Grade A).
- **Screening women aged 20 to 45** (Grade B Recommendation).
- There is no recommendation for or against routine screening for lipid disorders in men aged 20 to 35, or in women aged 20 and older who are not at increased risk for coronary heart disease. (Grade C).

Determining Risk for High Cholesterol

LDL Cholesterol – Primary Target of Therapy (mg/dL)	
< 100	Optimal
100-129	Near optimal / above optimal
130-159	Borderline high
160-189	High
> 190	Very High
Total Cholesterol	
< 200	Desirable
200-239	Borderline high
> 240	High
HDL Cholesterol	
< 40	Low
> 60	High

Identify presence of clinical atherosclerotic disease that confers high risk for coronary heart disease (CHD) events:
- Clinical Coronary Heart Disease (CHD)
- Symptomatic carotid artery disease
- Peripheral arterial disease
- Abdominal aortic aneurysm

Other major risk factors include:
- Cigarette smoking
- Hypertension (BP >140/90 mmHg or an antihypertensive medication)
- Low LDL cholesterol (<40 mg/dL)*
- Family history of premature CHD (CHD in male first degree male relative <55 years; CHD in female first degree relative <65 years)
- Age (mem >45years; women >55 years)

Recommendations for Treating High Cholesterol

(Source: Parks, 2008)

Along with weight management and increasing physical activity, patients can follow a cholesterol-reducing diet. Balance calories taken in and calories burned to keep desirable body weight and prevent weight gain.

Saturated Fat	Less than 7% of total calories
Polyunsaturated Fat	Up to 10% of total calories
Monounsaturated Fat	Up to 20% of total calories
Carbohydrate	50% to 60% of total calories
Fiber	20 to 30 grams per day
Protein	Approximately 15% of total calories
Cholesterol	Less than 200 mg per day

Parks, R. (2008, July 11). Healthwise: nutrient composition of the TLC diet for high cholesterol. Retrieved from http://www.med.nyu.edu/healthwise/article.html?hwid=zp3034
U.S. Preventive Services Task Force. (2008). Screening for lipid disorders in adults. Retrieved from http://www.uspreventiveservicestaskforce.org/uspstf/uspschol