

Help Your Patients Get Healthy for Summer

Summer is upon us, and with warm, sunny weather comes longer days, summer trips and visits from friends and family. For your older patients, keeping up with this increased activity can be a challenge – SilverSneakers® Fitness can help them conquer it.

SilverSneakers® is a benefit that comes (at no additional cost) with many Medicare plans— including Paramount Elite. While your Paramount Elite patients are eligible, many are not taking advantage of this benefit.

Their SilverSneakers benefit includes:

- a fitness membership at a local fitness location—plus access to 13,000+ locations nationwide— with access to exercise equipment, swimming pools, saunas and other amenities (varies by location)
- signature SilverSneakers® classes designed specifically for older adults and taught by certified instructors
- yoga and tai chi classes, walking groups and other activities held outdoors and at various neighborhood locations
- fun social events, a supportive online community and helpful resources

SilverSneakers® helps millions of members gain strength, improve balance and lead healthier lives. In fact, 62 percent of members in 2015 reported their health as “excellent” or “very good”¹ – compared to only 30 percent of older adults nationally.

The program works because it’s easy and fun. SilverSneakers® members aren’t just exercising—they’re getting out, making friends and improving their quality of life. Please refer your patients to silversneakers.com or 1-888-423-4632 (TTY:711) today to sign up and start taking advantage of this incredible health benefit.

¹Healthways SilverSneakers Annual Member Survey, 2015 (based on SF-12 scores)

IN THIS ISSUE:

Timeliness of Prenatal and Postpartum Care	page 2
Paramount’s Quality Improvement Program	page 2
Health Behavior and Assessment Intervention	page 3
Clinical Practice Guidelines	pages 4 & 5
ADD/ADHD Medication Follow-up Phone Call	pages 6 & 7
Healthchek	page 8
Healthcheck Billing Guidelines	page 9
FIT Testing Success	page 10
getBehindit Campaign	Page 11
Paramount Elite Program	Page 11
Safeguard in Utilization	Backcover

TIMELINESS OF PRENATAL AND POSTPARTUM CARE (AFFECTS THE QUALITY MARKERS)

ACOG (American College of Obstetricians and Gynecologists) recommends 14 visits for a 40-week pregnancy. Recommended visits include that women with an uncomplicated pregnancy receive visits every 4 weeks for the first 28 weeks of pregnancy, every 2–3 weeks until 36 weeks of pregnancy, and weekly thereafter. A postpartum visit should occur on or between 21 and 56 days after delivery. A postpartum visit should consist of:

- Pelvic exam
- Evaluation of weight, BP, breasts and abdomen
- Family planning

Many physicians are seeing patients at two weeks, then not to be seen again. If you want to see the patient within 7-14 days of delivery (i.e. cesarean delivery or a complicated pregnancy), you will need to schedule again before the 56 days or move their initial postpartum visit to 21 days or greater.

- Consider updating patient contact information at each prenatal appointment and with the information provided by the birth facility.
- Encourage patients who are eligible to take advantage of nurse home visits
- Provide counseling and education during the prenatal period and prior to discharge after delivery that emphasizes the importance of postpartum care and family planning.
- Provide access to contraceptives prior to discharge from the hospital or birthing center.

Paramount's Quality Improvement Program

Paramount's philosophy is that quality improvement is the duty of every employee and contracted provider. We are committed to using a continuous quality improvement cycle in managing both clinical and administrative services and measure performance indicators across all products. A summary of our Quality Improvement Program and Annual Quality Reports that highlight quality activities and performance on key indicators can be found at <http://www.paramounthealthcare.com/quality-program-and-reports>. For further information about the Paramount Quality Improvement Program, contact the Quality Hotline at 419- 887-2537, Member Services at 1-800-462-3589 (TTY 1-888-740-5670) or e-mail us at PHC.Quality@ProMedica.org

Health Behavior and Assessment Intervention (HBAI) Services

The Health Behavior and Assessment Intervention (HBAI) Services are used to identify and address the psychological, behavioral, emotional, cognitive, and social factors important to the treatment and management of physical health problems. HBAI is an established intervention designed to enable the member to overcome the perceived barriers to self-management of his/her chronic disease(s).

Paramount has determined that Clinical Psychologists may provide HBAI Services (CPT 4 codes 96150-96154) with limits for HMO, PPO, Individual Marketplace, & Elite members:

HBAI Services (CPT 4 codes 96150-96154) are non-covered for Advantage members.

Please consider referring your patients to a Clinical Psychologist for HBAI Services who meet all of the following criteria:

1. The patient has an underlying physical illness or injury, and
2. There are indications that biopsychosocial factors may be significantly affecting the treatment or medical management of an illness or an injury, and
3. The patient is alert, oriented and has the capacity to understand and to respond meaningfully during the face-to-face encounter, and
4. The patient has a documented need for psychological evaluation or intervention to successfully manage his/her physical illness, and activities of daily living, and
5. The assessment is not duplicative of other provider assessments.

Please call Provider Inquiry at 888-891-2564 or see Paramount Medical Policy PG0330 The Health and Behavioral Assessment/Intervention for further information: http://www.paramounthealthcare.com/documents/MedicalPolicy/PG0330_The_Health_and_Behavioral_Assessment-Intervention.pdf.



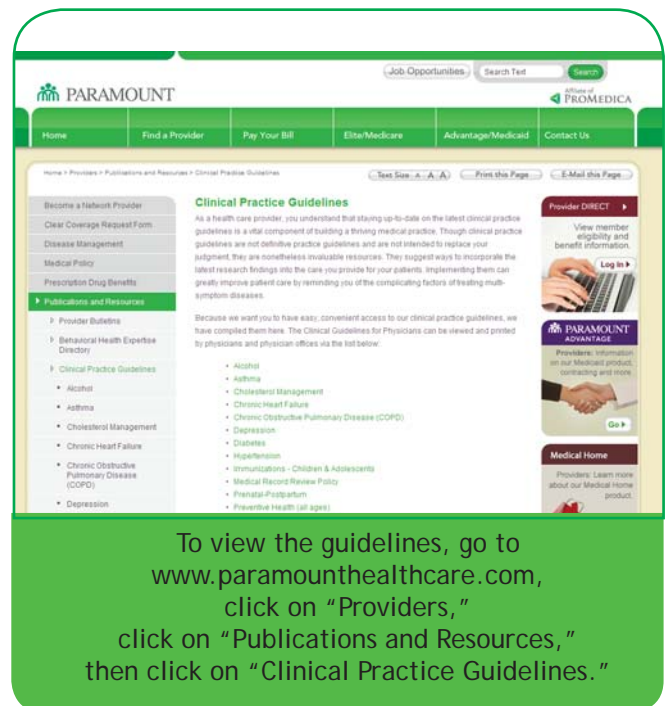
Clinical Practice Guidelines

The clinical guidelines for physicians and other practitioners can be reviewed and printed from the Paramount web site. These guidelines are evidenced-based and intended for use as a guide in caring for Paramount members. The Medical Advisory Council (MAC) reviews and approves each guideline annually. The guidelines are adopted from various nationally recognized sources. The guidelines will not cover every clinical situation and are not intended to replace clinical judgment.

In February 2016, the MAC adopted the American Diabetes Association Position Statement: Standards of Medical Care in Diabetes-2016. Srinu Hejeebu, DO, Associate Medical Director at Paramount, and Jack Brunner, MD, a Paramount provider specializing in endocrinology provided the review and supported the adoption.

Listed below are featured chapters and noteworthy changes:

1. Strategies for Improving Care – Recommendations for special populations, i.e., cognitive dysfunction/and/or mental illness, HIV, and those individuals with food insecurities. Also discusses disparities related to ethnicity, culture, gender, and socioeconomic differences.
2. Classification and Diagnosis of Diabetes – New recommendation to test all adults beginning at age 45 years of age, regardless of weight.
3. Foundations of Care and Comprehensive Medical Evaluation – This is a new title which combines section 3 “Initial Evaluation and Diabetes Management Planning” and section 4 “Foundations of Care: Education, Nutrition, Physical Activity, Smoking Cessation, Psychosocial Care, and Immunization”. These sections were merged to reflect the importance of integrating medical evaluation, patient engagement, and ongoing care.
4. Prevention or Delay of Type 2 Diabetes – A recommendation was added to encourage using the latest technology by patients and providers. Examples are software and mobile devices to affect lifestyle modification to prevent diabetes.
5. Glycemic Targets – New recommendation that reflect the growing older population using continuous glucose monitoring and insulin pumps who should have continued access after they turn 65 years of age.
6. Obesity Management for the Treatment of Type 2 Diabetes – This is a new section that incorporates prior recommendations related to bariatric surgery. There is a new recommendation related to the comprehensive assessment of weight in diabetes, and the treatment of overweight/obesity with behavior modification and pharmacotherapy. New table of currently approved medications for the long-term treatment of obesity is also included.



7. Approaches to Glycemic Treatment – Unchanged.
8. Cardiovascular Disease and Risk Management – “Atherosclerotic cardiovascular disease (ASCVD)” has replaced “Cardiovascular disease (CVD)”.
 - New recommendation for pharmacological treatment of older adults was added. Recommendation to consider aspirin therapy in women has changed from >60 years of age to ≥50 years.
 - A recommendation was made reflecting new evidence, that adding ezetimibe to moderate-intensity statin should be considered for additional cardiovascular benefits in select diabetic patients.
 - New table providing efficacy and dose details on high- and moderate-intensity statin therapy.
9. Microvascular Complications and Foot Care – “Nephropathy” was changed to “diabetic kidney disease”. Guidance was added on when to refer for renal replacement treatment, and when to refer to a specialist for the care of a patient with diabetic kidney disease.
10. Older Adults – This section is more comprehensive, with strong expert opinion recommending subtle changes in diabetes care in the older adult population. This section includes neurocognitive function, hypoglycemia, treatment goals, care in skilled nursing facilities/nursing homes, and end-of-life considerations.
11. Children and Adolescents – The recommendation to obtain a fasting lipid profile in children starting at age 2 years has been changed to age 10 years, based on a joint scientific statement on type 1 diabetes and cardiovascular disease from the American Heart Association and the ADA.
12. Management of Diabetes in Pregnancy – A1C recommendations for pregnant women with diabetes was changed, from a recommendation of <6% to a target of 6.0-6.5%. Depending on hypoglycemia risk the target may be tightened or relaxed.
13. Diabetes Care in the Hospital – This section was revised to focus solely on diabetes care in the inpatient hospital setting and addresses the following:
 - Hospital care delivery standards.
 - More detailed information on glycemic targets and anti-hyperglycemic agents.
 - Transitions from the acute care setting.
 - New table on basal and bolus dosing recommendations for continuous enteral, bolus enteral and parenteral feedings.
14. Diabetes Advocacy – Unchanged.

To view the complete guidelines go to www.paramounthealthcare.com, click on “Providers,” click on “Publications and Resources,” then click on “Clinical Practice Guidelines.”

Reimbursement Incentive

ADD/ADHD Medication Follow-up Phone Call

Commercial and Advantage Product Lines

Effective 11-1-12, updated June 2016

Successful medication therapy for Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) is directly related to follow-up care.

It has been shown that three (3) contacts with the patients by a practitioner increases compliance with the medication regimen. **One** follow up **face-to-face contact** should be made **between initiation and day thirty (30)** of medication therapy and **two contacts during days 31-300 of therapy**, one of which **may be a phone call** follow-up consultation. **Paramount reimburses for one phone consultation from your office to the patient.**

In order to meet the criteria for this additional reimbursement, the **phone consultation** should be made **during the maintenance phase** (days 31-300) of ADD/ADHD medication therapy. Such reimbursement is **limited to once per calendar year per qualifying member**. This call is intended to reinforce medication compliance and assess therapeutic effectiveness and is NOT a substitute for psychotherapy or other clinical services.

Criteria & Coding – Phone Consultation for ADD/ADHD Therapy	
Eligible Specialties: Family Practice, Internal Medicine, Pediatrics, & Behavioral Health	
ICD10 Codes Required for Payment	F90.0, F90.1, F90.2, F90.8 and F90.9
Required CPT Code	98966 non-physician; 99441 physician (5-10 minutes) 98967 non-physician; 99442 physician (11-20 minutes) 98968 non-physician; 99443 physician (21-30 minutes) (A telephone call from a physician/non-physician health care professional for consultation and/or medical management; simple and brief).
Documentation	Patient Chart documentation following phone call, include: <ul style="list-style-type: none"> • Date / Time / Length of Call • Summary of Discussion • Or, use the SCRIPT attached
Reimbursement & Co-payment	\$40.00 reimbursement per call for CPT codes 98966, 98967, 98968, 99441, 99442, 99443 No co-payment will be applied to the phone call.

Questions: Contact your Provider Relations Representative at:
(419) 887-2535 or (800) 891-2542



ADD/ADHD Follow-Up Telephone Visit (days 31-300 of treatment)

Name _____ ID # _____ Date _____

I'm calling to talk with you about your child who is taking medication for Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder:

1. Is your child still taking the medication?

Yes → **Go to Question 3**

No → **Go to Question 2**

2. Can you tell me why not? _____

If not yet filled, advise to fill script; repeat call in two weeks.

No further questions.

If filled but stopped taking, encourage making an appointment to discuss. **No further questions.**

3. Have you noticed any improvement in symptoms and/or behavior?

Yes → In what way(s) _____

Reinforce need to continue to take medication, even if symptoms have improved, to reduce the chance of having the symptoms return.

No → *Stress the need to continue the medication. May want to consider making an appointment to discuss dose adjustment or a different the medication.*

4. How is your child tolerating the medication? _____

List any side effects mentioned _____

Reinforce that many side effects disappear over time once the body adjusts to new medicines. If severe, schedule an appointment to discuss.

5. How is your child sleeping? (i.e. Falling asleep OK? Through the night? How many hours?) _____

6. How is your child's appetite? (How many meals a day? Weight gain/loss?) _____

7. Have you had any follow-up with your child's school, teachers, grades, etc?

Yes In what way? _____

No.....

8. Is there a follow-up visit scheduled?

Yes (Date) _____

No → *Schedule an appointment.*

9. Do you have any questions?

10. *(May want to consider pharmacy consult if on multiple medications, eg asthma, diabetes or psychiatric referral if multiple ADD/ADHD meds have been tried without success)*

Signature _____

Physician/Advanced Practitioner Signature _____

Healthchek is a federal and state (well-visit) mandate for *Medicaid* members from birth through the age of 20 years.

Healthchek Screening Service Frequencies

The Ohio Department of Medicaid (ODM) will follow the frequency recommendations for preventive pediatric health care developed by the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics (AAP). The AAP frequencies are as follows:

- Eight screens from newborn through 12 months;
- Exams at 15 months, 18 months, 24 months, 30 months, and;
- One screen per year from ages 3 through age 20.

Minimal Requirements of a Complete Healthchek Exam:

- Comprehensive Health and Developmental History
- Comprehensive Unclothed Physical Exam
- Health Education/Counseling and Anticipatory Guidance
- Developmental Assessment (Physical and Mental Health Development)
- Nutritional Assessment
- Vision Assessment
- Hearing Assessment
- Immunization Assessment
- Lead Assessment (Blood lead test at age 1, again at age 2, and when medically indicated)
- Laboratory Tests (When medically indicated)
- Dental Assessment



Provider Role:

- Perform and document complete Healthchek exams during sick and well visits
- Bill according to guideline
- Educate members on importance of well visits, immunizations, dental visits, and blood lead testing

ODM and Paramount monitor compliance with the Healthchek standards on an annual basis via administrative claims data and random medical record documentation auditing for HEDIS®.

Healthchek/Well-Visit Billing Guidelines

Codes to identify Healthchek/well visits are listed below. Please note:

Effective October 1, 2015							
New Preventive Medicine Codes (ICD-10 CM Diagnosis codes)							
Z00.00	Z00.01	Z00.110	Z00.111	Z00.121	Z00.129	Z00.5	Z00.8
Z02.0	Z02.1	Z02.2	Z02.3	Z02.4	Z02.5	Z02.6	Z02.71
Z02.79	Z02.81	Z02.82	Z02.83	Z02.89	Z02.9		

New Patient Service (CPT 4 – E/M codes)			Established Patient Service (CPT 4 – E/M codes)		
99381	99382	99383	99391	99392	99393
99384	99385	99461	99394	99395	

Documentation of Healthchek Screening Services

All components of a complete Healthchek must be documented in the member's medical record. Should a Healthchek examination be refused, this refusal and any given reasons for this refusal must be documented in the patient's medical record.

The entire Healthchek Guideline is available on the Paramount web site at <http://www.paramounthealthcare.com>. Click on Providers, Publications and Resources, Healthchek then Paramount Advantage Healthchek Program. In the center of the screen are 17 age-specific Well Child Exam forms. These forms may be printed and copied at no charge. If you currently have your own well visit forms, please compare them to the age-specific forms to ensure all the components of a complete Healthchek exam are included. A Healthchek power point presentation is also available as well as a great educational piece for office staff. For more information, contact Terri Anello, RN, Quality Improvement Coordinator at 419-887-2301 or Terri.Anello@ProMedica.org.

***FIT* Testing a Success!**

Although there is a wealth of information available on the importance of preventive screenings, many of our members resist having a colonoscopy. Last year, the Paramount Quality Improvement (QI) Department identified 2,556 Elite members who, as of July 15th, 2015, had not been screened for colorectal cancer. In an effort to promote preventive screening for colon cancer during the month of September, QI Coordinators sent each identified member a FIT Kit (Fecal Immunochemical Test) which identifies any occult (hidden) blood found in the stool. According to the United States Preventive Services Task Force (USPSTF), the FIT Test offers an increase in accuracy for detecting colorectal cancer early compared to the guaiac test since the results of the test are not affected by food or medication.

Collaboration with ProMedica Laboratories made this project possible. They purchased the FIT Kits which were mailed out to members with specific directions on using the kit and returning it by mail to ProMedica Labs. The results were available through the ProMedica portal; members with a positive result (an unfavorable finding for the member) were identified and the QI Coordinator doing the tracking was notified by ProMedica Labs. Positive results were communicated to the member's primary care provider by Paramount.

Offering options to members is an important aspect of engaging them to complete a simple screening procedure. Of the 29% who participated:

- 8.5% were identified for additional screening with 19 members having multiple polyps removed,
- 12 were diagnosed with other types of colon disease,
- 18 did not follow up with physician advice for colonoscopy/further testing,
- 2 went to the Veterans Administration who will not share information,
- 9 had subsequent normal colonoscopy findings,
- 4 members flatly refused any further testing and
- 1 member underwent a hemi-colectomy subsequent to a follow up colonoscopy.

These results show how important colorectal cancer screening is and early intervention prevents more serious disease.

Rates for colorectal cancer screening for Paramount Elite increased significantly as a result of this project, increasing from 68.6% in 2014 to 82% in 2015. Because of the success of the 2015 program, the QI Department will repeat the FIT Test screening project with our Elite members this fall. We hope you will support this effort by encouraging your patients to participate and providing follow up as needed.



getBehindit!

Colorectal cancer is the second leading cause of cancer death in the United States among men and women combined, yet it's one of the most preventable. The number of colorectal cancer cases is dropping thanks to screening.

How can you be part of the national effort to make sure 80% of adults ages 50 and older are regularly screened for colorectal cancer by 2018?

As a primary care physician, here are five things that you can do to be a part of 80% by 2018:

- Understand the power of the physician recommendation. Recommend colorectal cancer screening to your patients ages 50 and older, as well as to younger patients at an increased risk of disease. They may need to start screening at an earlier age.
- Measure the colorectal cancer screening rate in your practice; it may not be as high as you think.
- Have standing protocols in place to make sure every age – and risk-eligible – patient gets a recommendation when they are due for screening.
- Understand the screening options for colorectal cancer.
- Make sure that patients and staff understand that most insurance companies are required to cover colorectal cancer screening.

Learn more about colorectal cancer screening at <https://promedicahealthconnect.org/search/colorectal>.

For questions about whether this service is within a Paramount member's benefit plan and covered in full, contact Paramount Member Services Monday-Friday, 8 a.m. to 5 p.m. at 419-887-2525 or outside the area, toll free at 800-462-3589.

Focusing on Wellness for Paramount Elite

A special wellness focused presentation will be held on August 17, 2016 at 6:00pm in the Paramount auditorium for our Elite members. Healthy dinner choices will be offered along with beverages. Issues targeted will be preventive health visits with their primary care provider, nutrition for maintaining a healthy brain and body, and exercise for strength and balance, with a Tai Chi interactive session. Please encourage your Paramount Elite patients to join in the fun!



Affiliate of ProMedica



NETWORKNEWS

*Provided as a service to our Provider
and Office Manager Community*

Published By:

Paramount
1901 Indian Wood Circle
Maumee, OH 43537
419-887-2500

Editor: Mindy Cross
mindy.cross@promedica.org

Communicating with the physician and his or her office staff is very important to Paramount. This newsletter will be published biannually, with emphasis on topics that relate to physician and staff participation in the plan.

PHC-NN-SpSu-2016

NetworkNews

Safeguard In Utilization

Utilization Management (UM) decision making is based only on appropriateness of care and service and availability of coverage. Paramount does not reward practitioners or other individuals for issuing denials of coverage or care. Paramount does not provide financial incentives for UM decision-makers to encourage decisions that result in underutilization. Additionally, Paramount's staff (UM/CM/BH Coordinators) cannot deny services based on medical necessity. These denials can only be made by our Medical/Associate/Clinical Directors, Pharmacists or a Paramount-designated sub-specialist.

