PARAMOUNT
Affiliate of ProMedica

NetworkNews

a publication of Paramount

Provided as a service to our Provider and Office Manager Community
Spring/Summer 2017

Help Your Patients Get Healthy for Summer!

Summer is upon us, and with that sunny weather comes longer days and plenty of travel. For your older patients, keeping up with this increased activity can be a challenge – **SilverSneakers® fitness** can help.

SilverSneakers is a benefit that comes (at no additional cost) with many Medicare plans. Your **Paramount Elite** patients may be eligible but not yet taking advantage of this benefit.

Their SilverSneakers® benefit includes:

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

SilverSneakers® helps millions of members gain strength, improve balance and lead healthier lives. In fact, **94%** of members in 2016 reported their health as good to excellent, and among participants not exercising prior to enrolling in SilverSneakers®, **61%** now report exercising three or more days per week.[1]

The program works because it's convenient, fun and affordable. SilverSneakers® members aren't just exercising—they're getting out, getting healthier, making friends and improving their quality of life.

Please encourage your patients to visit **silversneakers.com** or call **1-888-423-4632** (TTY:**711**) today to start taking advantage of this incredible health benefit.

[1]SilverSneakers® Annual Member Survey, 2016 (based on SF-12 scores)

IN THIS ISSUE:

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 four weeks for the first 28 weeks of pregnancy, every two to three 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.

Tobacco Cessation – Ohio Quit Line

Tobacco use is the single most preventive cause of death. According to reports from the Ohio Department of Health, Ohio smokers want (and are trying) to quit. The Ohio Behavioral Risk Factor Surveillance System, reported that in 2015, approximately three out of five Ohio smokers made an attempt to quit in 2015, equating to about 1.1 million people.

Paramount partners with the Ohio Quit Line to provide free NRT and counseling for our members. Paramount members are no exception to wanting to quit and actively utilize the quit line (change to a period). According to the numbers in 2016:

- 206 intakes in 2016 (69 to date for 2017)
- 42% age 45 or older, 67% female
- 78% smoked/used tobacco for 10+ years
- 56% had three or more past quit attempts
- 48% had children in the home
- 58% were single
- 53% reported a mental health condition

Help your patients make one of the best decisions for their health by providing a support system to quit smoking. Members can call 1-800-784-8669 (1-800-QuitNow) or visit https://ohio.quitlogix.org to sign up and start living a healthier life style today.

DAWG POUND HEALTHY REWARDS

Paramount *Advantage* and the Cleveland Browns will continue the ***Dawg Pound Healthy Rewards (DPHR) program in 2017.*** This program is designed to encourage our Paramount *Advantage* members to get their Yearly Wellness Checkup/Routine Annual Physical with their PCP every year. ***Dawg Pound Healthy Rewards*** is offered to eligible* Paramount *Advantage* members, age 12 months and older, who register (online or through the mail) and have a Yearly Wellness Checkup/Routine Annual Physical in 2017. Those who do will be entered into monthly drawings to win great prizes from the Browns.

NEW THIS YEAR! Provider offices are now eligible to win prizes! You must have members that had a Yearly Wellness Checkup/Routine Annual Physical AND registered for the DPHR program in 2017. You'll be entered for a chance to win game tickets or a VIP Training Camp experience. The more members that qualify and register the more chances you have to win. Good luck!

For more information and member online registration, visit: **www.ParamountAdvantage.org/Browns**

***Due to NFL franchise rules**, **Paramount Advantage members in the following counties are not eligible**: Adams, Brown, Butler, Clark, Clermont, Clinton, Darke, Greene, Hamilton, Highland, Miami, Montgomery, Preble, and Warren.

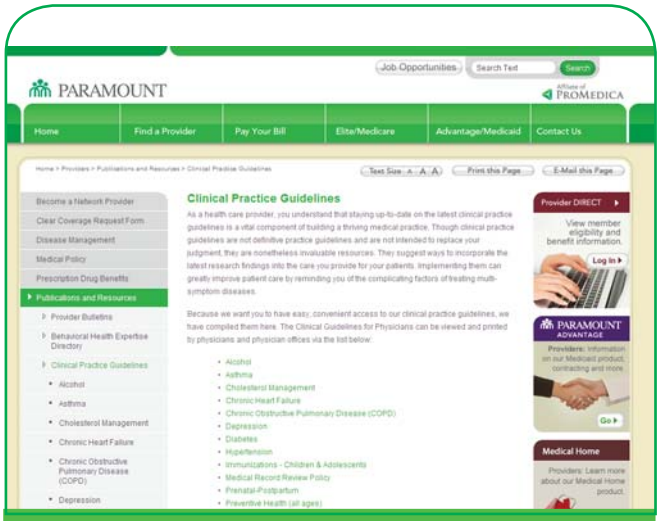
GET YOUR WELL ON

The Get Your Well On incentive program will continue in 2017. It is only offered to those Paramount Advantage members living in the 14 counties that are excluded from the Dawg Pound Healthy Rewards program due to NFL franchise rules. It is also an incentive program to encourage members 12 months and older to have their Yearly Wellness Checkup/Routine Annual Physical with their PCP. Once Paramount receives the invoice for the well visit, the member will be entered in a monthly drawing for a chance to win a Samsung Galaxy Pro Tablet with Wi-Fi and Bluetooth.

*Participating counties include: Adams, Brown, Butler, Clark, Clermont, Clinton, Darke, Greene, Hamilton, Highland, Miami, Montgomery, Preble, and Warren.

Clinical Practice Guidelines

The clinical guidelines for physicians and other practitioners can be reviewed and printed from the Paramount website. 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.



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

• **Chronic Obstructive Pulmonary Disease Guideline** This guideline is based on the Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease, updated 2017; At-A-Glance Outpatient Management Reference for Chronic Obstructive Pulmonary Disease (COPD), updated 2017; and Pocket Guide To COPD Diagnosis, Management, And Prevention. A Guide For Health Care Professionals, Updated 2017. One major significant revised change involved changing the the definition of COPD. This guideline was adopted March, 2017.

• **Recommended 2017 Childhood Immunization Schedule** This schedule has been released by the Centers for Disease Control and Prevention (CDC). The Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Family Physicians (AAFP) have endorsed this immunization schedule. The immunization schedule was adopted April, 2017.

•**Diabetes Guideline** In March 2017, the MAC adopted the American Diabetes Association Position Statement: Standards of Medical Care in Diabetes-2017. Srini Hejeebu, DO, Associate Medical Director at Paramount, and Richard Beham, MD, a Paramount provider specializing in endocrinology provided the review and supported the adoption. Listed below are featured chapters and noteworthy changes:

1. Promoting Health and Reducing Disparities in Populations – New recommendation for tailoring treatment to reduce disparities by following the Chronic Care Model that emphasizes productive interactions between a well prepared health care team and an informed activated patient.

2. Classification and Diagnosis of Diabetes – New consensus on the staging of type 1 diabetes and new discussion of proposed unifying diabetes classification scheme that focuses on B-Cell dysfunction and disease stage indicated by glucose status.
   - New- Due to recent data, delivering a baby weighing 9 lbs or more is no longer listed as an independent risk factor for development of pre-diabetes and type 2 diabetes.
   - New- Section was added to discuss recent evidence on screening for diabetes in dental practices.

3. (New) Comprehensive Medical Evaluation and Assessment of Comorbidities – This chapter highlights the importance of assessing comorbidities in the context of a patient–centered comprehensive Medical Evaluation.
   - New recommendation to assess sleep patterns and duration as part of the comprehensive medical evaluation (new evidence suggesting relationship between sleep quality and glycemic control).
   - Expanded list of comorbidities now include: autoimmune disease; HIV; anxiety disorders; depression; disordered eating behavior; and serious mental illness.

4. Lifestyle Management – Based on new evidence of glycemic benefits, the Standards of Care now recommend that prolonged sitting be interrupted every 30 minutes with short bouts of physical activity.
    - A new section and table provides information on situations that might warrant referral to a mental health provider.

5. Prevention or Delay of Type 2 Diabetes– Because of new evidence showing an association between B12 deficiency and long term Metformin use, a recommendation was added to consider periodic measurement of B12 levels and supplementation, as needed.

6. Glycemic Targets – Based on recommendation from an international hypoglycemia study group, serious, clinically significant hypoglycemia is now defined as glucose <54mg/dl while the glucose alert value is defined as ≤70mg/dl. Clinical complications are discussed in this section.

7. Obesity Management for the Treatment of Type 2 Diabetes – To be consistent with other ADA Position Statements, Bariatric Surgery is now referred to as Metabolic Surgery.

8. Pharmacologic Approaches to Glycemic Treatment – New evidence showing an association of B12 deficiency and long term Metformin use.
    - New recommendation to consider periodic measurement of B12 levels and supplementation as needed.

9. Cardiovascular Disease and Risk Management – To better align with existing data, the hypertension treatment recommendation for diabetes now recommends for patients without albuminuria, any of the four classes of blood pressure medications ACE Inhibitors, Angiotensin Receptor blockers, Thiazide-like diuretics, or dihydropyridine calcium channel blockers may be used.
    - Section added describing the cardiovascular outcome trials that demonstrated benefits of Empagliflozin (Jardiance) and Liraglutide (Victoza) in certain high risk patients with diabetes.

10. Microvascular Complications and Foot Care – Now includes specific recommendations for the treatment of neuropathic pain (either Pregabalin or Duloxetine are recommended as the initial pharmacologic agents for the treatment neuropathic pain in diabetes).

11. Older Adults – Hypoglycemia should be avoided in older adults with diabetes. It should be assessed and managed by adjusting glycemic targets and pharmacologic interventions.

12. Children and Adolescents – To address diagnostic challenges associated with the current obesity epidemic, a discussion was added about distinguishing between type 1and type 2 diabetes in youth.

13. Management of Diabetes in Pregnancy – Insulin was emphasized as the treatment of choice in pregnancy based on concerns about the concentration of Metformin on the fetal side of the placenta and glyburide levels in cord blood.

14. Diabetes Care in the Hospital – This section was reorganized for clarity.
    - Sole use of sliding scale insulin in the inpatient hospital setting is strongly discouraged.
    - Perform an A1C for all patients with diabetes or hyperglycemia admitted to the hospital if not performed in the prior 3 months.

15. 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: • 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

1901 Indian Wood Circle | Maumee, Ohio 43537 | www.paramounthealthcare.com

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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 website at http://www.paramounthealthcare.com. Click on Providers, Publications and Resources, Healthchek then Paramount Advantage Healthchek Progam. 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 Jan Schwarzkopf, MSN, RNC-OB, Healthchek Maternal/Child Program Manager at 419-887-2598 or Jan.Schwarzkopf@ProMedica.org.

Medication Reconciliation after Hospital Discharge

To help improve post discharge medication reconciliation rates, the following documentation needs to be included in the medication reconciliation process for patients after an acute or non-acute inpatient discharge:

1. Verification that discharge medications were reconciled with the most recent medications in the outpatient medical record.
2. Performed within 30 days after discharge.
3. Signed and dated by a prescribing practitioner, RN or clinical pharmacist.

Administrative CPT codes that indicate successful medication reconciliation	CPT Codes
Transitional Care Management Services	99495, 99496
Medication Reconciliation	1111F

NEW!! Prenatal Risk Assessment Communication

The Prenatal Risk Assessment (PRA) form, ODM 03535, is now **OBSOLETE.** It has been replaced by the Prenatal Risk Assessment Communication form (PRAF 2.0). Form ODM 10207 and accompanying instructions ODM 10207i, (3/2017) are available on the Ohio Department of Medicaid website. http://medicaid.ohio.gov/RESOURCES/Publications/MedicaidForms.aspx

Completion of this form enables three critical steps:

1) **Notify Paramount and the County Department of Job and Family Services (CDJFS) about the member's pregnancy to maintain her Medicaid coverage** (Paramount will communicate with the CDJFS).

2) **Address identified needs (smoking cessation, alcohol and drug abuse, transportation, behavioral health) for the Paramount Care Management team to assist.**

3) **Expedite progesterone receipt [Hydroxyprogesterone Caproate (HPC) injection "17P", Makena or vaginal progesterone].**

For all Ohio **Medicaid** patients seen in your practice/clinic, completely fill out the PRAF, ODM 10207 forms:

- *Notification of Pregnancy only* - Fax page 1 to Paramount Advantage.
- *Notification of Pregnancy with Care Management needs* – Fax page 1 to Paramount Advantage.
- *Progesterone Candidacy* – Fax pages 1 and 2 to Paramount Advantage, contracted Home Health Agency and Specialty Pharmacy .
- Continue to use HCPCS code H1000 when billing for initial and subsequent submissions, if updates are needed.

WEB-BASED PRAF 2.0 Notification System COMING SOON

To continue to increase efficiencies, the Ohio Department of Medicaid is moving this new form to a **web-based** platform. This system will allow providers to simultaneously notify managed care plans and county departments of job and family services (CDJFS) of a woman's pregnancy so that her eligibility is not disrupted and she can be efficiently connected with services.

Other key benefits of the new system will include:

- Faxing to multiple end users will no longer be required.
- Prescriptions and home health referrals for progesterone and its administration are processed in real time.
- Provider staff can save online forms to allow for updates by multiple users prior to submission, and once submitted all completed forms remain available online.
- CDJFS pregnancy and readiness coordinators will receive daily notifications of newly identified pregnancies.
- Managed health care plans can download information into their care management systems for more efficient connections to care.

More details and training opportunities will be available within the next few months to prepare for the launch of the new web-based system.

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.

FIT Testing a Success

Although there is a wealth of information available on the importance of preventive screenings, many of our members resist screenings for colorectal cancer. Rates for colorectal cancer screening for Paramount Elite increased significantly as a result of the FIT Kit (Fecal Immunochemical Test) project in 2015, from 68.6% in 2014 to 82% in 2015. Due to the success of the 2015 program, the Paramount Quality Improvement (QI) Department will repeat the FIT Test screening project with our Elite members and expand to our Marketplace members this summer, running through year end. In an effort to promote preventive screening for colon cancer during the months of July and August, QI Coordinators will send identified members in our Elite and Marketplace product lines a FIT Kit which identifies any occult (hidden) blood found in the stool. According to the United States Preventive Services Task Force (USPSTF), the FIT Test offers a more accurate test than the guaiac for detecting colorectal cancer earlier, since the FIT results are not affected by food or medication.

Collaboration with ProMedica Laboratories continues to make this project possible. They have purchased the FIT Kits scheduled for mailings to appropriate members. Specific directions on using the kit and returning it by mail to ProMedica Labs are included. The results will be available through EPIC for PPG Providers. Members with a positive result (an unfavorable finding for the member) will be identified and the member's PCP will be notified to insure further evaluation and treatment.

We hope you will promote this effort by encouraging your patients to participate and providing appropriate follow up. Thank you for your ongoing support of Paramount's Quality Improvement initiatives.

PARAMOUNT

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PRSRT STD
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TOLEDO, OH

NETWORKNEWS

Provided as a service to our Provider and Office Manager Community

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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-2017

Safeguard In Utilization

Utilization Management (UM) decision making is based only on appropriateness of care and the existence of coverage. Utilization management staff and associate medical/clinical directors are not financially or otherwise paid to encourage underutilization and/or denials of coverage or care. In fact, Paramount monitors and analyzes monthly reports for patterns of underutilization and takes action to address any identified problems. In addtion, nursing staff cannot deny services - denials can be made only by board certified, locally participating physicians.

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.