



HAWAI'I | SPRING 2009

PROVIDER

Newsletter

WEB REGISTRATION IS FAST AND EASY

To take advantage of 'Ohana's Web site, go to www.ohanahealthplan.com and follow these simple steps:

1. Create a new account using the *Sign up Here* link that appears on the home page. The *Register Here* link on the top right side of the following page will direct you to the Provider Registration form.
2. Complete the registration form. Your 'Ohana-issued Provider ID appears in your welcome packet and on your Explanation of Payment copies.
3. Create a user name. A confirmation page will be displayed. You should print this page for your records.
4. Within 24 hours of registration, you will receive an e-mail with a temporary password that will expire in 30 days. Use this password to log onto the 'Ohana site and create a password of your preference.

Be sure to keep your user name and password information somewhere safe for future reference.

PROVIDER MATERIALS UPDATE

The following correspondence was sent to providers recently via the Web site's messages or by fax. At www.ohanahealthplan.com, click on the *Provider* tab, and you will see *Messages from 'Ohana* located in the right-hand column. Remember to check messages regularly to receive new and updated information.

WEB RESOURCES

'Ohana Preventive and Clinical Practice Guidelines, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) documents, pharmacy guidelines, the Cultural Competency Plan and other helpful resources are available at www.ohanahealthplan.com.

A summary of the Cultural Competency Plan is available in Section 13 of the 'Ohana Medicare Provider Manual and Section 14 of the 'Ohana Medicaid Provider Manual. If you would like to receive a copy of the complete Cultural Competency Plan, please contact your Provider Relations representative.

For additional information, please contact Provider Services at 1-888-846-4262 for Medicaid or 1-888-505-1201 for Medicare.

SEE THE VALUE OF ANNUAL EYE EXAMS

Please encourage your patients to get an annual eye examination.

It is 'Ohana's goal for every member to receive a routine eye exam annually. If you have patients who have not yet had an annual eye exam, please remind them to schedule an appointment.

Consult the **Quick Reference Guide** to refer members to the appropriate contracted vision vendor.



MEDICAID

CHILD HEALTH CHECKUP TIPS

‘Ohana members are entitled to receive a comprehensive package of preventive health care. Here are some questions and answers to help you conduct, document and bill for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

Question: How often should a member receive an EPSDT exam?

Answer: EPSDT exams should be administered as follows:

- 0–4 weeks of age
- 2 months of age
- 4 months of age
- 6 months of age
- 9 months of age
- 12 months of age
- 15–18 months of age
- 2 years of age
- 3 years of age
- 4 years of age
- 5 years of age
- 6 years of age
- Even years up to age 20
- Dental screens every six months starting at one year old

Question: What must I do to perform an EPSDT exam?

Answer: An EPSDT exam has five components that must be provided:

- A comprehensive health history—includes an assessment of physical, behavioral and mental development
- A comprehensive unclothed exam

- Health education, including anticipatory guidance
- Lead risk assessment
- Immunizations and tuberculosis testing

Question: To ensure I get credit for doing an EPSDT exam, how should I document it in my patient’s record?

Answer: Documentation in the medical record must include a note indicating a visit with a primary care practitioner, the date the EPSDT visit occurred, and evidence of all of the required components listed above. Providers must use the 8015 or 8016 form to document completion of the service. Form 8015A may be used if additional documentation is needed.

There are several forms available that can assist you in ensuring you have documented correctly. You may find these forms:

- In your ‘Ohana Provider Manual (Forms section)
- By calling ACS at **1-808-952-5570**

Question: How do I bill for EPSDT exams?

Answer: Bill for an EPSDT exam using the following codes:

AGE OF CHILD	NEW PATIENT	ESTABLISHED PATIENT
0–1 year of age	99381	99391
1–4 years of age	99382	99392
5–11 years of age	99383	99393
12–17 years of age	99384	99394
18–20 years of age	99385	99395

Acceptable ICD-9 code: V20.2

Please be sure to use the correct CPT code based on the patient's age.

When submitting the claim, the original 8015, 8015A, 8016 must be included. 'Ohana will ensure that a copy of the form is submitted to ACS per state regulations. 'Ohana will make referrals to our Service Coordination or Disease Management programs per recommendations made by the provider.

Providers referring the member either back to themselves or to a specialist for follow-up treatment of a condition identified during the preventive visit must record an "E" indicator in the FL 24H field of the CMS 1500. The "E" indicator is recorded only when a referral for follow-up treatment or evaluation is done.

A global fee reimbursement for the complete medical screen includes costs associated with any mandatory or optional office procedures like drawing blood and immunization administration. Vaccines available through the federally funded Department of Health (DOH) Vaccines for Children (VFC) program are not eligible for reimbursement.

A reduced global fee is allowed to provide "catch-up" immunizations for members who have not completed immunizations recommended for an earlier age. The fee includes a brief office visit to ascertain the absence of acute illness, review of the immunization schedule and its administration and counseling. "Catch-up" visits should be billed using 90471–90474 with an "EP" modifier. Providers should use form 8016 to document the "catch-up" services provided and submit the original form with their bill. Providers may bill only one global service per day and may not bill for the service during the same visit as an EPSDT preventive visit.

Anticipatory guidance is a required part of a complete EPSDT and well-child exam. Further, to receive credit for an EPSDT exam, you must document that the guidance was given.

For more information on EPSDT and well-child exams, please visit the 'Ohana Provider Resources posted on www.ohanahealthplan.com.

Source: American Association of Pediatrics

BREAK THE CODE FOR BETTER CARE AND SERVICE

Concise medical record documentation is critical to providing patients with quality care as well as for receiving accurate and timely reimbursement for rendered services.

Medical records chronologically document the care of the patient and are required to record pertinent facts, findings and observations about the patient's health history. Documentation should include past and present illnesses, examinations, tests, treatments and outcomes. Medical record documentation also assists physicians and other health care professionals in evaluating and planning the patient's immediate treatment and monitoring health care over time.

The Evaluation & Management Services Guide is a tool that includes Centers for Medicare & Medicaid Services (CMS) reference tools, publications and Web site links with documentation guidelines.

The 2008 version of the CMS guide for E&M Medical Record Documentation is available at www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf.

Source: Evaluation & Management Services Guide, July 2008 http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf



A LITTLE MOTIVATION CAN MAKE A BIG DIFFERENCE

Motivational interviewing is a skill that clinicians can employ on a day-to-day basis to influence patient recovery. The practice helps a patient deal with his or her conscious and unconscious resistances to change through exploration, clarification and encouragement by the clinician during the medical visit.

As defined by Miller and Rollnick, motivational interviewing is a direct, client-centered counseling style for eliciting behavior change by helping patients explore and resolve ambivalence.

Principles of motivational interviewing are as follows:

- Motivation to change is elicited from the patient, not imposed by others.
- It is the patient's task, not the clinician's, to articulate and resolve his or her ambivalence.
- Direct persuasion is not an effective method for resolving ambivalence.
- The counseling style is usually quiet and eliciting.
- The counselor is direct in helping the patient examine and resolve ambivalence.
- Readiness to change is not a patient trait but a fluctuating product of interpersonal interaction.
- The therapeutic relationship is more like a partnership or companionship than expert and recipient roles.

In order to ensure that motivational interviewing is most effective, the clinician:

- Listens to what the patient has to say

- Respects and appreciates the patient's individuality, independence and right to make the final decisions about his or her life and health care
- Seeks to understand the patient's frame of reference, particularly via reflective listening
- Acknowledges the patient's ambivalence
- Acts as a resource enabling the patient to identify the barriers to change and how to change
- Focuses on strengths but explores weaknesses shared by the patient
- Expresses encouragement, empathy, understanding, acceptance and affirmation
- Elicits and selectively reinforces the patient's expressions of problem recognition, concern, desire and intention to change, and ability to change
- Monitors the patient's degree of readiness to change and ensures that resistance is not generated by jumping ahead of the patient
- Affirms the patient's freedom of choice and self-direction

The goal is to support self-efficacy and optimism, giving the patient hope that, in time, things can be better. All patients need hope. Even the most treatment-resistant patients need hope that things can improve.

Source: Miller WR, Rollnick S. Motivational Interviewing: Preparing People for Change. 2nd Ed. New York: Guilford Press; 2002

GLUCOMETER AND TESTING SUPPLY VENDORS

'Ohana maintains a list of preferred glucometers and testing supplies for patients with diabetes. The preferred glucometers and test strips for 'Ohana are shown at right:

ROCHE	ABBOTT
Preferred Glucometers	
Accu-Chek® Active Care Kit	FreeStyle Lite® Meter
Accu-Chek® Advantage Care Kit	FreeStyle Freedom® Lite Meter
Accu-Chek® Aviva Care Kit	Precision Xtra® Meter
Accu-Chek® Compact Plus Care Kit	
Preferred Test Strips	
Accu-Chek® Active Test Strips	FreeStyle Lite® Test Strips
Accu-Chek® Advantage Test Strips	Precision Xtra® Test Strips
Accu-Chek® Aviva Test Strips	
Accu-Chek® Comfort Curve Test Strips	
Accu-Chek® Compact Test Drums	

MITIGATE RISKS OF ANTIPSYCHOTIC POLYPHARMACY

Concomitant use (polypharmacy) of antipsychotics is widely prevalent and is prescribed for long durations of time (about eight months).^{1,2} It is an increasing phenomenon among schizophrenia patients, indicating a significant discrepancy with treatment guidelines that do not advocate the use of any polypharmacy except for short-term periods when transitioning patients to new antipsychotics.^{1,2,4}

Currently, research is dominated by case reports and uncontrolled studies evaluating polypharmacy.¹ Particular weaknesses of the present research are:

- Low number of participants
- Lack of adequate control of confounding factors
- Short duration of experimental follow-up and inadequate monitoring of potential adverse effects.¹

Further research, including randomized, double-blind placebo-controlled studies evaluating the effects of antipsychotic polypharmacy in schizophrenia patients, is needed to assist in defining the scope and potential of such use.

Polypharmacy is associated with increased risk of metabolic syndrome, increased body weight and Parkinsonism-like symptoms.¹ Long-term follow-up

shows increased mortality in patients taking two or more antipsychotics.⁵ Furthermore, polypharmacy was not associated with superior clinical improvement or shorter hospitalization.³ At this time, polypharmacy with antipsychotics is not recommended for long durations.

Sources:

- 1) Ganguly R, Kotzan JA, Miller S et al. Prevalence, trends, and factors associated with antipsychotic polypharmacy among Medicaid-eligible schizophrenia patients, 1998–2000. *J Clin Psychiatry* 2004;65:1377–1388
- 2) Tranulis C, Skalli L, Lalonde P et al. Benefits and risks of antipsychotic polypharmacy: An evidence-based review of the literature. *Drug Safety* 2008;31 (1):7–20.
- 3) Mckean A, Vella-Brinkat J. An Audit of Antipsychotic Polypharmacy. PowerPoint Presentation. Accessed from: http://www.nzpha.org.nz/psych_sig/MHpresentations08/antipsychotics%20polypharmacy.pdf
- 4) National Institute of Clinical Experience. Guidance on the newer (atypical) antipsychotic drugs for the treatment of schizophrenia. Health Technology Appraisal No. 43 available from www.nice.org.uk 2002.
- 5) Centorrino et al. Use of combinations of antipsychotics: McLean Hospital Inpatients, 2002. *Human Psychopharmacology* 2005;20(7):485–492.

GENERIC DRUG NEWS AND FORMULARY UPDATES

Listed below are generic drugs that have become available recently:

BRAND NAME	GENERIC NAME	THERAPEUTIC CLASS
Cosopt® 2%-0.5% Ophthalmic Solution	Dorzolamide HCl/Timolol Maleate 2%-0.5% Ophthalmic Solution	Antiglaucoma Agent
Imitrex® STATdose System	Sumatriptan Succinate 4mg/0.5mL, 6mg/0.5mL Solution for Injection	Antimigraine Agent
Keppra® Tablet	Levetiracetam Tablet	Anticonvulsant Agent
PhosLo® Gelcaps 667mg Capsule	Calcium Acetate 667mg Capsule	Phosphate Binding Agent
Razadyne® Tablet	Galantamine Hydrobromide Tablet	Cholinesterase Inhibitor
Razadyne® ER Extended-Release Capsule	Galantamine Hydrobromide Extended-Release Capsule	Cholinesterase Inhibitor
Retrovir® 50mg/5mL Syrup	Zidovudine 50mg/5mL Oral Syrup	Antiviral Agent
Tobradex® 0.3%-0.1% Ophthalmic Suspension	Tobramycin/Dexamethasone 0.3%-0.1% Ophthalmic Suspension	Ophthalmic Anti-infective/ Anti-inflammatory Combination
Trusopt Ocumeter® 2% Ophthalmic Solution	Dorzolamide HCl 2% Ophthalmic Solution	Antiglaucoma Agent
Videx® EC Delayed-Release Capsule	Didanosine Delayed-Release Capsule	Antiviral Agent

REGULAR CERVICAL CANCER TESTING CAN SAVE LIVES

‘Ohana invites its physicians to help reinforce the importance of cervical cancer screening to our female members. Our Pap test recommendations are as follows:

- Females should receive an initial Pap test within three years of first sexual activity or at age 21—whichever comes first.
- Cervical cancer screenings should occur once every three years until age 65.
- Women older than 65 should discontinue Pap testing only after they have had several negative tests and are not otherwise at risk for cervical cancer.
- Women living with HIV/AIDS should have a Pap test twice in the first year, and if the tests are normal, Pap tests should continue at least every year.
- A woman who has had a total hysterectomy (in which the cervix was removed) no longer needs Pap tests, unless the surgery was done as a treatment for cervical abnormalities or cancer.

Health care providers should encourage patients who may be less likely to get Pap tests to be screened regularly.

- All primary care providers, not just gynecologists, should check if women need to have a Pap test and, if so, either perform the test or refer appropriately.
- Targeted outreach toward older, foreign-born, low-income and uninsured women is recommended.
- All women 21 and older should be screened at least every three years, regardless of sexual activity.

Sources: National Cancer Institute; U.S. Department of Health and Human Services; American Cancer Society

MEDICAID

BREASTFEEDING: THE NATURAL CHOICE FOR HEALTH

SHOWS GREAT POTENTIAL TO ENHANCE MATERNAL AND CHILD HEALTH

With few medical exceptions, the American Academy of Family Physicians recommends that most mothers breastfeed their babies exclusively for the first six months and in combination with other foods until at least 12 months. Breastfeeding is not recommended for women with HIV and certain other conditions.

Promotion and support of breastfeeding should begin in prenatal care and continue after delivery and during pediatric care. Unless medical contraindications exist, babies should be put to their mother’s breast within the first hour after birth.

The American Academy of Pediatrics recommends a schedule of supplementing breastfeeding with Vitamin D drops until the infant begins to consume at least 500 ml of commercial formula. Pediatric providers should be able to refer families to local lactation consultants and support services. Structured educational programs are more effective than written materials alone. Refer to the resources listed below for more information.

FOR PROVIDERS:

- Breastfeeding policies and resources: www.aafp.org, www.acog.org, www.aap.org and www.apha.org
- Safety of maternal medications during breastfeeding: www.perinatology.com/exposures/druglist.htm
- International Lactation Consultant Association: www.ilca.org
- Academy of Breastfeeding Medicine: www.bfmed.org

FOR FAMILIES:

- The National Women’s Health Information Center: www.4women.gov/breastfeeding or 1-800-994-9662

Source: American Academy of Family Physicians; American Academy of Pediatrics



COORDINATION OF CARE MAXIMIZES OUTCOMES

A recent Google™ search identified more than 11 million documents related to coordination of care. With so much information available, one might think that it is a commonly used phrase or practice, but it is not routinely utilized by all health care professionals. 'Ohana reminds providers that coordination of care is appropriate for all disciplines at all levels of care, including inpatient-outpatient, medical-behavioral, PCP-specialty and intradisciplinary.

Communication and coordination/integration of care between medical and behavioral health providers is a best practice principle essential to optimizing patient safety and clinical outcomes.

Patients with co-morbid medical and behavioral health conditions can be particularly vulnerable to complications that may result from inadequate coordination of care between treating providers. All providers, medical and behavioral, are expected to initiate communication that facilitates and enhances continuity of care, relapse prevention, patient safety and satisfaction.

It must be noted, though, that health care providers can coordinate care only to the extent permitted by confidentiality requirements. There may be occasions when the patient refuses to sign consent for release of information.

Keeping in mind the ultimate goal of enhanced patient well-being, it behooves all parties to take the necessary steps for coordination of care.

Source: National Archives and Records Administration

WHAT IS HEDIS®?

HEDIS® (Healthcare Effectiveness Data and Information Set) consists of a set of performance measures utilized by more than 90 percent of American health plans that compare how well a plan performs in these areas:

- Quality of care
- Access to care
- Member satisfaction with the health plan and doctors

WHY HEDIS® IS IMPORTANT

HEDIS® ensures health plans are offering quality preventive care and service to members. It also allows for a true comparison of the performance of health plans by consumers and employers.

VALUE OF HEDIS® TO YOU, OUR PROVIDERS

HEDIS® can help save you time while also potentially reducing health care costs. By proactively managing patients' care, you are able to effectively monitor their health, prevent further complications and identify issues that may arise with their care.

HEDIS® can also help you:

- Identify noncompliant members to ensure they receive preventive screenings
- Understand how you compare with other 'Ohana Health Plan providers as well as with the national average

VALUE OF HEDIS® TO YOUR PATIENTS, OUR MEMBERS

HEDIS® ensures that members will receive optimal preventive and quality care. It gives members the ability to review and compare plans' scores, helping them to make informed health care choices.

Source: www.ncqa.org

WHAT YOU CAN DO

- Encourage your patients to schedule preventive exams
- Remind your patients to follow up with ordered tests
- Complete outreach calls to noncompliant members

If you have questions about HEDIS® or need more information, please contact your local Provider Relations representative.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)



'Ohana Health Plan
Plaza at Mill Town
94-450 Mokuola Street
Waipahu, HI 96797

PRSRT STD
U.S. POSTAGE
PAID
WELLCARE

HI09603_WCG_NEW_ENG
©WellCare 2009 HI_01_09

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.

25821

MEDICAID

'OHANA HEALTH PLAN SERVICE COORDINATION MODEL

The Plan values the care our provider partners give our members. To ensure the most beneficial health outcomes, 'Ohana employs a Service Coordination system for our QUEST Expanded Access (QExA) members.

SYSTEM OF COORDINATING CARE

Each member is assigned a Service Coordinator who works with the Primary Care Physician to coordinate the primary, acute and long-term care services and to ensure continuity of care. Some of the services include:

- Working with you to coordinate the team of decision-makers to develop the care plan, including any providers as appropriate, the member and others as determined by the member, including family members, caregivers and significant others
- Conducting comprehensive face-to-face health and functional assessments (HFAs)
- Developing a working care plan based upon results of assessment
- Monitoring progress with EPSDT requirements
- Coordinating services with providers such as Medicare,

Department of Health programs, Medicare Advantage plans and other Managed Care Organization providers

- Utilizing encounter data to ensure services meet member needs
- Facilitating access to services
- Referring members to Disease Management coordinators for education and resources regarding their chronic or high-risk illnesses
- Providing assistance in resolving any concerns about care delivery or providers

This model is unique in that each member has a Service Coordinator who is a registered nurse, licensed social worker or another type of clinician. It is a comprehensive, member-centric model in which the member's needs are assessed and met. Significant emphasis is placed on keeping members in the community (own home, family member's home, community personal home) instead of placing them in institutions.

Members may contact the Service Coordination department at **1-888-846-4262**.