Provider Report™

Stimulating Health IT

The federal economic stimulus law enacted in February will boost health information technology with $17.2 billion in incentives available to physicians and hospitals that adopt electronic health records (EHRs). The bonus money will be paid through the Medicare and Medicaid programs from 2011 through 2016. The earlier the adoption, the larger the bonus.

Physicians should review both programs' requirements and incentives and decide which one is right for their practice. In brief:

- Medicare bonuses are paid once a qualifying EHR system is in place, with a maximum $44,000 paid over a four-year period of "meaningful use" of the system.
- Medicaid incentives include a year-one startup grant of up to $25,000 to help fund IT acquisition, with maximum annual bonuses of $10,000 paid for four additional years of meaningful use.

Physicians who don't adopt EHRs will have their Medicare or Medicaid reimbursements progressively reduced: by 1 percent in 2015, 2 percent in 2016, and so on up to 5 percent.

Clarification of "meaningful use," still to come from the Health and Human Services Secretary, will spell out required capabilities, such as electronic prescribing.

Only 17 percent of U.S. physicians currently use EHRs, so reaching the Congressional Budget Office's projection of 90 percent adoption within five years is a major challenge. The ultimate goal of widespread EHR use is improved quality and efficiency, which is expected to result in significant, ongoing savings.

To review the programs and their requirements, check out David Blumenthal's recent article at http://content.nejm.org/cgi/content/full/NEJMp0901592. Blumenthal was recently named National Coordinator for Health Information Technology by President Obama.

Information regarding Buckeye's 2009 Quality Improvement Program Description is available for review upon request.

Looking Out for Members

Our care management staff help create better outcomes.

By Monique Gladden
Care Manager, Buckeye Community Health Plan

As processes become more streamlined within our care management system, Buckeye Community Health Plan's (Buckeye's) care management staff has made great strides with members and providers in this process.

The care management team assists members with finding in-network providers, from PCPs to specialists. We also develop working relationships with providers to facilitate care for members who have become disgruntled with the healthcare system and have not made their own health a priority.

We perform assessments that often result in the disclosure of an array of needs from the member. The care manager works closely with the member to meet those needs by performing tasks such as obtaining DME, referring a specialist, and sometimes simply making a phone call to clarify health concerns.

Complex cases are discussed with our medical director on a frequent basis to increase our focus on medically difficult members to help facilitate the best medical outcome. We make cost containment and overall health benefits for the member a priority. Thus, we are able to create optimal health outcomes for them.

Member education is an important piece of the care management process. It empowers individuals to take more control of their own health while decreasing unnecessary ER usage. Program specialists are an integral part of the care management team, working with members to help them with issues such as housing, evictions, food and other bare necessities that might have previously distracted the member from dealing with his or her health issues.

Our care management team is building great relationships, member by member!

Did you know? InterQual criteria are available for your review by request.

2 Get the Basics About HealthChek Exams
3 New CMS Requirements For Hospital Transitions
4 In Focus: Elective Induction of Labor

Time for a HealthChek? Get the basics about these exams.

The HealthChek (EPSDT) exam is a federally mandated health-care service available to Medicaid-eligible people from birth through age 20. The goal of HealthChek exams is to keep children and teens healthy by performing exams early and on a set schedule.

The Healthchek/EPSDT components include an unclothed physical exam, height, weight, health history, nutrition assessment and screenings, including subjective, objective developmental; oral health; hearing and vision; risk assessments; anticipatory guidance/health education and appropriate referrals; laboratory testing (including anemia and lead) and up-to-date immunizations.

EPSDT stands for:
EARLY: a check of a child's health as soon as possible by a primary care provider.
PERIODIC: regular appointments with providers for regular scheduled visits (see table at right).
SCREENING: special tests or regular exams.
DIAGNOSIS: determining if a child has any health problem(s).
TREATMENT: treating a child's health problem(s).

When should a child have a HealthChek/EPSDT visit?

UNDER AGE 1		Birth, 1, 2, 4, 6 and 9 months
AGE 1 TO 2		12, 15, 18, 24 and 30 months
AGE 3 THROUGH AGE 20		Every year

Buckeye's Prior Authorization Process

By Ronald Charles, M.D., MHA, FACP, FACHE, Vice President, Medical Affairs
Mary Pearson, Manager, Utilization Management
Buckeye Community Health Plan

The prior authorization process can sometimes seem like a maze, yet it is quite easy to maneuver. Buckeye Community Health Plan has moved the prior authorization process to its various regional offices in an effort to serve you, the provider, more efficiently and effectively.

Our current speed in answering your calls is a fraction of what you were accustomed to in the past. And, you now have direct access to our prior authorization nurses, who are available Monday through Friday from 8 a.m. to 5 p.m. to handle your prior authorization requests. Our nurses are capable of addressing your requests via phone, fax and Web portal.

We are also pleased to announce that our average turnaround time is less than four days for non-urgent requests. We address all urgent requests within 24 hours.

You can assist us with ensuring a rapid turnaround time by doing the following:

- Providing relevant clinical information, including past treatment history.
- Making certain that the clinical information is legible.
- Ensuring that appropriate CPT codes are submitted with each request.
- Providing appropriate diagnostic codes.
- Submitting requests and clinical information on a timely basis.

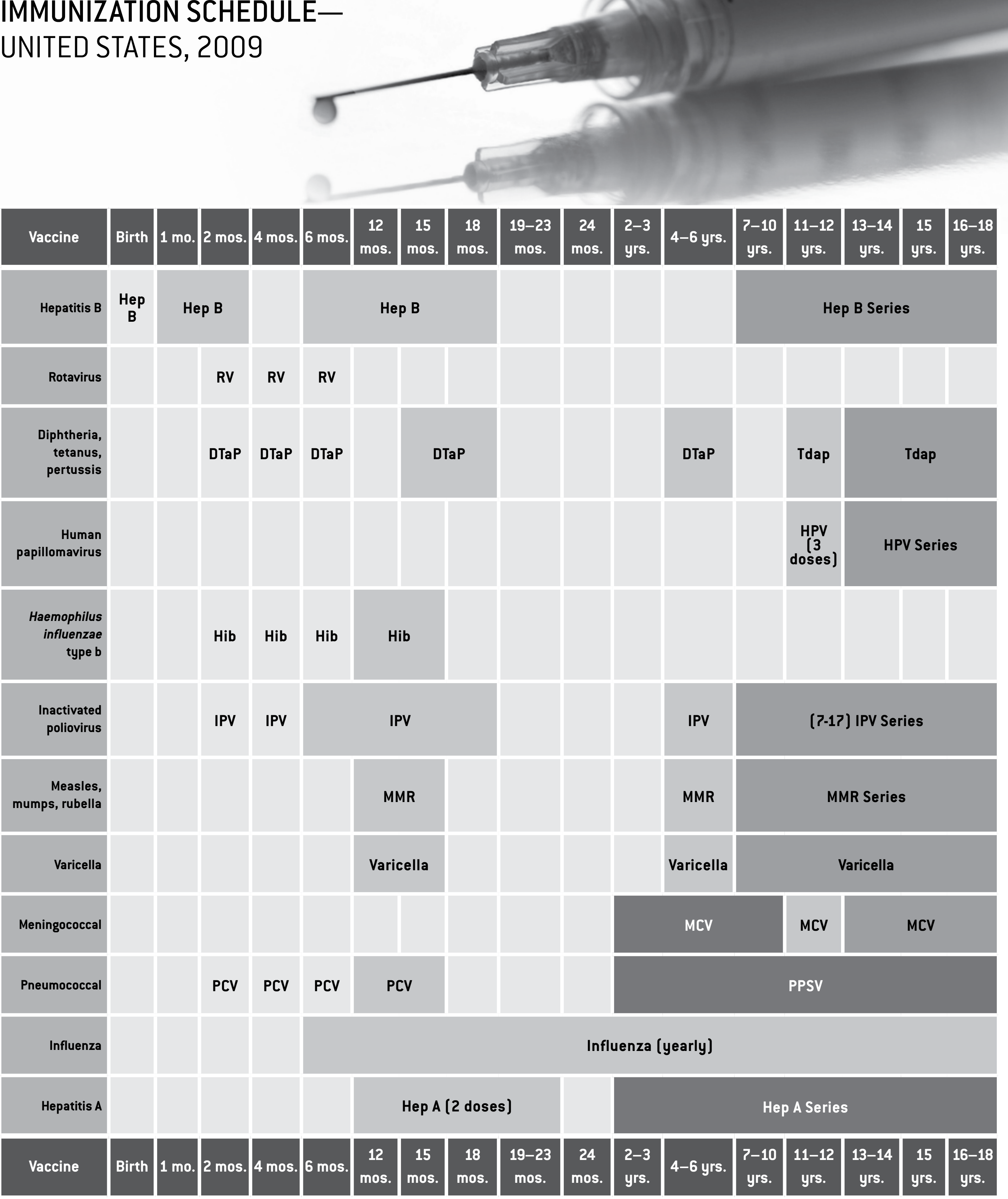
Buckeye's goal is to work collaboratively with you to facilitate the high quality of care that you provide to our patient population.

CPT Category II Codes

CPT Category II codes are supplemental codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of CPT Category II codes allows specific services, test results and other similar data to be captured at the time of service, thus reducing the need for retrospective medical record review.

Use of these codes is optional and is not required for correct coding and may not be used as a substitute for Category I codes. However, Buckeye encourages use of these codes. As noted above, submission of these codes can minimize the administrative burden on providers by greatly decreasing the need for medical record review, particularly related to health plan HEDIS reporting.

THE FOLLOWING ARE CPT CATEGORY II CODES APPLICABLE FOR HEDIS MEASURES:	
Hemoglobin A1c Levels	3044F, 3045F, 3046F, 3047F
LDL-C Levels	3048F, 3049F, 3050F
Nephropathy Screening Results	3060F, 3061F
Systolic B/P Levels	3074F, 3075F, 3076F, 3077F
Diastolic B/P Levels	3078F, 3079F, 3080F
Prenatal Care Visits	0500F, 0501F, 0502F
Postpartum Care Visits	0503F
Medication Reconciliation	1111F



RECOMMENDED **CHILDHOOD AND ADOLESCENT IMMUNIZATION SCHEDULE**— UNITED STATES, 2009

Vaccine	Birth	1 mo.	2 mos.	4 mos.	6 mos.	12 mos.	15 mos.	18 mos.	19–23 mos.	24 mos.	2–3 yrs.	4–6 yrs.	7–10 yrs.	11–12 yrs.	13–14 yrs.	15 yrs.	16–18 yrs.
Hepatitis B	Hep B	Hep B			Hep B								Hep B Series				
Rotavirus			RV	RV	RV												
Diphtheria, tetanus, pertussis			DTaP	DTaP	DTaP		DTaP					DTaP		Tdap	Tdap		
Human papillomavirus														HPV (3 doses)	HPV Series		
Haemophilus influenzae type b			Hib	Hib	Hib	Hib											
Inactivated poliovirus			IPV	IPV	IPV							IPV	(7-17) IPV Series				
Measles, mumps, rubella						MMR						MMR	MMR Series				
Varicella						Varicella						Varicella	Varicella				
Meningococcal											MCV			MCV	MCV		
Pneumococcal			PCV	PCV	PCV	PCV					PPSV						
Influenza					Influenza (yearly)												
Hepatitis A						Hep A (2 doses)					Hep A Series						
Vaccine	Birth	1 mo.	2 mos.	4 mos.	6 mos.	12 mos.	15 mos.	18 mos.	19–23 mos.	24 mos.	2–3 yrs.	4–6 yrs.	7–10 yrs.	11–12 yrs.	13–14 yrs.	15 yrs.	16–18 yrs.

RECOMMENDED **IMMUNIZATION SCHEDULE FOR CHILDREN AND ADOLESCENTS**

(WHO START LATE OR WHO ARE MORE THAN ONE MONTH BEHIND)

Catch-Up Schedule for Children Ages 4 Months Through 6 Years

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Diphtheria, tetanus, pertussis	6 wks.	**4 weeks**	**4 weeks**	**6 months**	**6 months**
Inactivated poliovirus	6 wks.	**4 weeks**	**4 weeks**	**4 weeks**	
Rotavirus	6 wks.	**4 weeks**	**4 weeks**		
Hepatitis B	Birth	**4 weeks**	**8 weeks** (and at least 16 weeks after first dose)		
Measles, mumps, rubella	12 mos.	**4 weeks**			
Varicella	12 mos.	**3 months**			
Haemophilus influenza type b	6 wks.	**4 weeks** If first dose given at age <12 months **8 weeks (as final dose)** If second dose given at age 12–14 months **No further doses needed** If first dose given at age ≥15 months	**4 weeks** If current age <12 months **8 weeks (as final dose)** If current age ≥12 months and second dose given at age <15 months **No further doses needed** If first dose given at age ≥15 months	**8 weeks (as final dose)** This dose only necessary for children ages 12 months–59 months who received 3 doses before age 12 months	
Pneumococcal	6 wks.	**4 weeks** If first dose given at age <12 months and current age <24 months **8 weeks** (as final dose for healthy children) If first dose given at age ≥12 months or current age 24–59 months **No further doses needed** For healthy children if first dose given at age ≥24 months	**4 weeks** If current age <12 months **8 weeks** (as final dose for healthy children) If current age ≥12 months **No further doses needed** For healthy children if previous dose given at age ≥24 months	**8 weeks (as final dose)** This dose only necessary for children ages 12 months–59 months who received 3 doses before age 12 months or for high-risk children who received 3 doses at any age	
Hepatitis A	12 mos.	**6 months**			

Catch-Up Schedule for Children Ages 7 Years Through 18 Years

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses		
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4
Tetanus, diphtheria/Tetanus, diphtheria, pertussis	7 yrs.	**4 weeks**	**4 weeks** If first dose given at age <12 months **6 months** If first dose given at age 12 months or older	**6 months** If first dose given at age <12 months
Inactivated poliovirus	6 wks.	**4 weeks**	**4 weeks**	**4 weeks**
Human papillomavirus	9 yrs.	Routine dosing intervals are recommended		
Hepatitis A	12 mos.	**6 months**		
Hepatitis B	Birth	**4 weeks**	**8 weeks** (and at least 16 weeks after first dose)	
Measles, mumps, rubella	12 mos.	**4 weeks**		
Varicella	12 mos.	**3 months** If first dose given at age <13 years **4 weeks** If first dose given at age ≥13 years		

Website Information For Providers

The provider pages of Buckeye's website offer an array of tools to help you manage your business needs and access information of high importance to you. This information includes patient eligibility listings, provider searches and claims submissions and status checks.

All contracted providers should visit the website at bchpohio.com to register and create a username and password to begin using the available services. Doing so will give our providers access to items like:

- Enhanced member eligibility verification, including enrollment history.
- Improved claims review with detailed information regarding claims status.
- Updated online prior authorization.
- Updated online claims submission.

For more information about our website or for questions about enrolling, please call our Provider Services Department at 1-866-296-8731.

Opportunities Exist for Quality Improvement

CMS implements new Medicare guidelines for hospital transitions.

The Centers for Medicare and Medicaid Services (CMS) reports that nearly one in five patients who leaves the hospital today will be readmitted within the next month, and that more than three-quarters of these readmissions are potentially preventable. As a result, CMS has launched a number of **new requirements for providers and Medicare Advantage plans aimed at promoting seamless transitions for beneficiaries as they move from the hospital to a home, skilled nursing care or home healthcare.** These requirements are summarized in the table to the right.

CMS expects Medicare Advantage plans and network hospitals to work together to **reduce unnecessary admissions and maintain members in the least restrictive setting,** the setting that best aligns with the member's preferences while allowing for clinically appropriate and fiscally responsible management of the member's health.

WHAT CMS EXPECTS OF BUCKEYE	WHAT CMS EXPECTS OF YOU
Identify planned and unplanned transitions within one business day of occurring.	Network hospitals and long-term care facilities to notify the member's Medicare Advantage plan within one business day of admission.
Contact the member's usual provider (e.g., PCP, nursing facility). Encourage the provider to share the member's plan of care (e.g., current medications, diagnoses, co-morbidities, complications, current condition, past history, etc.) with the receiving facility.	Be willing to share clinical information. This includes the member's current plan of care.
Follow up with the receiving provider as necessary.	Help us identify any gaps in care as members move between settings.
Coordinate services and support members and providers through transitions.	
Educate members about how to avoid unplanned transitions (e.g., emergency admissions).	

This can only be done by working together. If you have ideas about how we can work together to meet these requirements, please let us know.

For more information or to discuss a particular member, please contact Buckeye Medical Management at 1-866-246-4359.

Putting Cultural Competency Into Practice

Any efforts to improve healthcare quality must incorporate cultural competency, which is the provision of equitable, patient-centered care across diverse populations. Despite widespread efforts to close racial, ethnic and cultural gaps, disparities persist:

- Cancer death rates among African-American men in 2007 are 33 percent higher than among whites—almost identical to rates reported in 1981.
- Although obesity-related chronic conditions are more prevalent among minorities, doctors were more likely to counsel obese whites than African-Americans and Hispanics about exercise.
- Compared with their white counterparts, older Hispanic and African-American adults are much less likely to be vaccinated against influenza and pneumococcal disease.

You can help to meet the cultural competency challenge in your practice with the help of a free online training tool from the Health Resources and Services Administration. "Unified Health Communication 101: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency" is a five-module course approved for CME credit. Visit hrsa.gov/healthliteracy/training.htm.

Get the Lead Out

It's a fact: lead poisons people.

Lead poisoning is most common in small children. Kids get lead poisoning by eating or chewing on paint, dirt or toys that contain lead. Children should have a blood lead test at 12 and 24 months of age. Please talk to your members to find out if their children are due for a lead test.

For additional information, please refer to the state of Ohio lead testing requirements and medical management recommendations at www.odh.ohio.gov or contact the Ohio Childhood Lead Poisoning Prevention Program (OCLPPP) at (614) 466-5332 with questions.

Elective Induction of Labor

By Ronald Charles, M.D., MHA, FACP, FACHE
Vice President, Medical Affairs, Buckeye Community Health Plan

Induction of labor in the U.S. has been on a steady rise since the 1980s, with a sharper increase in elective inductions versus medically indicated inductions of labor. Elective inductions at 37 to 38 weeks currently account for approximately 17.5 percent of live births in the U.S. The American College of Obstetricians and Gynecologists (ACOG) guidelines permit elective inductions only after 39 weeks gestational age and suggest that a favorable cervix be documented to negate the need for cervical ripening. These guidelines were established to minimize prematurity-related neonatal complications, which have been associated with deliveries before 39 weeks.

Several studies have demonstrated increases in neonatal morbidity associated with early delivery. One study, which analyzed 17,794 deliveries, documented admission to the NICU in 17.8 percent of infants electively induced at 37 to 38 weeks. This rate dropped to 8 percent between 38 and 39 weeks, and decreased further to 4.6 percent with deliveries after 39 weeks. The average length of stay in the NICU was 4.5 days for those delivered prior to 39 weeks. Cervical status at the time of induction was also noted to be directly correlated with the risk of Cesarean delivery in both nulliparous and parous women.

Another study, which analyzed 179,701 births, demonstrated that severe RDS was 22.5 times higher for infants born at 37 weeks, and 7.5 times higher at 38 weeks, when compared to infants born between 39 and 41 weeks. Transient tachypnea, pulmonary hypertension, NICU admissions, prolonged hospital stays beyond five days, and other morbidities are significantly increased in early-term elective deliveries. Follow-up data from this study showed significant declines in postpartum anemia, meconium aspiration, low apgar scores, and C-sections due to fetal distress in those infants induced between 39 and 41 weeks, as compared to those elective inductions performed before 39 weeks.

Several studies have documented significant decreases in the incidence of elective induction of labor prior to 39 weeks by simply applying and enforcing the existing ACOG guidelines, which were originally established in 2004 using gestational age, parity and cervical status to determine the appropriateness of induction of labor without medical indications.

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PBO

Provider Services: 1-866-296-8731
Member Services: 1-866-246-4358

Visit Buckeye Community Health Plan online at bchpohio.com.

US Bank Building
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Columbus, OH 43215

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