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Coordination of Care with Members

We define “coordination of care” as making sure that the PCP knows the member’s health care history and is involved in all aspects of the member’s care. We encourage members to select a CP physician and to inform the PCP of any care they receive not rendered by the PCP. One aspect of care not always communicated to the PCP by the member is after hours or emergency care. Our QI/UM Committee has approved standards for physician accessibility including 24 hour availability. Primary care practices should have off access to a physician 24 hours a day, seven days a week. The answering service/machine should answer 100 percent of the time and if an answering machine is used, it must provide emergency instruction 100 percent of the time. When you see one of our members in your office, please remind him or her of your availability 24 hours a day, seven days a week.

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Pittsburgh Area: Free HCV Screenings at Giant Eagle Specialty Pharmacies

What: As part of Hepatitis Awareness Month in May, Giant Eagle Specialty Pharmacy will be offering free HCV screenings to customers

Why: CDC is recommending that everyone born during 1945 through 1965, also known as baby boomers, get a blood test for Hepatitis C.
- People with Hepatitis C:
often have no symptoms
- can live for decades without feeling sick
- can be successfully treated with medications

- The CDC's Hepatitis C testing recommendation was made because:
  - there are high rates of Hepatitis C in people born during 1945-1965 (people born during 1945-1965 are 5 times more likely than other adults to be infected)
  - testing can help prevent deaths from Hepatitis C (it is estimated that one-time testing of everyone born during 1945-1965 will prevent more than 120,000 deaths)
  - there is a lack of awareness (many people with Hepatitis C do not know that they have Hepatitis C)
  - there have been recent advances in treatment (for many people with Hepatitis C, medical treatment can result in the virus no longer being detected in the blood)

**When:** The screenings will be held at the dates/times below at 4 Pennsylvania Pharmacy locations

- Saturday, April 27, 10 a.m.- 2 p.m.
- Saturday, May 4, 10 a.m.- 2 p.m.
- Saturday, May 11, 10 a.m.- 2 p.m.
- Saturday, May 18, 10 a.m.- 2 p.m.

**Where:** The Giant Eagle Pharmacy locations in Pennsylvania with our Patient Consultation Centers:

- Monroeville Giant Eagle
  4010 Monroeville Blvd.
  Monroeville, PA 15146

- South Hills Market District
  7000 Oxford Dr.
  Bethel Park, PA 15102

- Robinson Market District
  100 Settlers Ridge Center Dr.
  Pittsburgh, PA 15205

- Township of Pine Market District
  155 Towne Centre Dr.
  Wexford, PA 15090

Customers do not need to bring anything with them for the testing, they can simply just show up at one of the selected locations during the event times. In addition to the screener from US Wellness and our Giant Eagle pharmacists, a doctor or nurse will also be present at each event to help answer questions

Analysis of 2011 Hospital Discharge Summaries received by Primary Care Providers - HealthAmerica Continuity of Care Audit

HealthAmerica conducted a hospital discharge summary project with the primary care providers during the summer of 2012. The purpose of the study was to assess coordination of care across transition of care from inpatient to post-discharge follow-up by reviewing outpatient medical records for evidence of hospital discharge summaries. The study included 380 members with an inpatient admission, 223 PCP offices, and 92 hospitals. This review documents compliance with the following accreditation requirements:

- NCQA Standard QI 10 – Continuity and Coordination of Medical Care – The organization monitors and takes action, as necessary, to improve continuity and coordination of care across the health care network.
• CMS Standard CC02 – Timely Communication of Clinical Information – The MAO must ensure continuity and coordination of care through procedures for timely communication of clinical information among providers, with the member, and his/her designees if applicable.

Findings:
The overall response rate for the 2011 study was 88.2% of PCP offices, which represents an increase over the 2010 response rate of 84.3%. Three-hundred-and-thirty-five (335) inpatient admissions were reviewed and a total of 65.1% (218/335) outpatient records did contain the hospital discharge summary. This number is very close to the 2010 compliance rate of 65.8%.

Based on the findings in this audit, 34% of the time hospitals do not provide PCPs with hospital discharge summaries after an inpatient stay. The Quality Improvement department appreciates your cooperation with this audit and encourages you to remember the importance of continuity of care when you follow up with your patients, including appropriate documentation of recent inpatient hospitalizations.

HEDIS Measure: Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (HealthAmerica: Commercial, Medicare and Medicaid)

Rheumatoid Arthritis is a chronic inflammatory disorder that typically affects small joints in the hands and feet, and is three times more common in women than in men. Since the beginning of 2012, 443 HealthAmerica members have been diagnosed with rheumatoid arthritis (RA) and have qualified for the HEDIS measure. HEDIS has very strict criteria for members to be in the population, so these members definitely have the disease and need to be monitored.

Through the Healthcare Effectiveness Data and Information Set (HEDIS), the National Committee for Quality Assurance requires us to collect information for our members diagnosed with rheumatoid arthritis. According to HEDIS, patients diagnosed with rheumatoid arthritis need to have had at least one ambulatory prescription dispensed for a disease modifying anti-rheumatic drug (DMARD). Having access to this health care information will improve the performance of care to our members. The Rheumatoid Arthritis Measure is currently a STAR measure for Medicare.

The table below outlines our current score and the national average for this measure. Medicaid data is not available due to low number of members that qualify for the RA measure.
Please continue to support us by following the guidelines of care for rheumatoid arthritis for patients diagnosed with RA as appropriate and provide the necessary information to us. The health and happiness of our members are top priority for our organization in addition to our providers continuing to deliver top-notch quality care to our members.

If you have any questions or suggestions for interventions for this measure, please contact Kathleen Piedmonte at 412-553-5580.

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**Diabetes Clinical Practice Guidelines Updated**

Updated clinical practice guidelines for diabetes were adopted by the Coventry Mid-Atlantic Region Quality Improvement/Utilization Management Committee at a recent meeting. The diabetes guidelines were adapted from the American Diabetes Association’s 2013 Clinical Practice Recommendations.

The Mid-Atlantic Region updates guidelines at least every two years or sooner if changes are made by the developing organization. To access the guidelines, click here. Clinical practice guidelines can also be obtained by calling your Provider Relations representative or by calling Kimberly Clash RN, Quality Improvement supervisor at 1-800-788-6445, extension 2810.

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**Results of HealthAmerica 2012 Medical Record Documentation Review**

On at least an annual basis, the Quality Improvement department conducts a medical record documentation audit of medical records obtained from a random sample of primary care physicians in the state of Pennsylvania. The purpose of this audit is to evaluate the quality of medical record keeping and to determine if the Plan’s medical record documentation standards are being met.

For the 2012 audit, medical records were chosen from a random sample of records of Medicare, Medicaid, and Commercial members. Primary care sites included internal medicine, pediatrics, and family practice. Both multi-physician practices as well as solo physician practices were included in the sample. The medical records were reviewed by Quality Improvement staff and Registered Nurses using the 2012 Medical Record Audit Tool. The Audit Tool is based upon the 2012 Medical Record Documentation Standards. Ninety-five charts were reviewed from 33

<table>
<thead>
<tr>
<th>HealthAmerica</th>
<th>Current Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthAmerica Commercial HMO/POS</td>
<td>91.72 %</td>
<td>87.75 %</td>
</tr>
<tr>
<td>HealthAmerica Medicare HMO/POS</td>
<td>76.82 %</td>
<td>74.06 %</td>
</tr>
<tr>
<td>HealthAmerica Medicare PPO/PA</td>
<td>83.70 %</td>
<td>74.06 %</td>
</tr>
</tbody>
</table>
unique PCP offices. After completion of the review, each PCP practice received a pass/fail. A total score of 70% or greater represented a passing score.

Standards reviewed in the 2012 audit were:

- Presence of a completed problem list
- Prominent notation of allergies or adverse reaction to medications
- Documentation of past medical history
- Consistency of physical exam and treatment plan with diagnosis
- List of current medications including dosage and frequency
- Documentation of medically appropriate care
- Documentation that an advance directive had been discussed with patients age 65 or over
- Security of medical records
- Yearly training of staff in confidentiality of medical records

Significant findings for the 2012 audit were:

- Seventeen practices missed one standard and two practices missed two standards.
- 87.8% of the practices use electronic medical records (29 out of 33)
- The following two standards had a score less than 90%.
  - Documentation of appropriate past medical history
  - “The record for members age 65+ contains documentation of discussion and/or an Advance Directive”.

100% of the practices received a passing score of 70% or above. One notable finding was that 62% of the practices did not have an advance directive or mention of an advance directive in the member’s chart (for members 65 or older). This number increased from 56% in 2011. Resources for providers on advance directives can be found on the Pennsylvania Medical Society website: [http://www.pamedsoc.org](http://www.pamedsoc.org) (for providers in Pennsylvania) or the Midwest Care Alliance website [http://www.ohpco.org](http://www.ohpco.org) (for providers in Ohio).

The Medical Record Documentation Guidelines are reviewed and updated as needed annually. These guidelines are based on the requirements of the National Committee for Quality Assurance (NCQA), Centers for Medicare (CMS), and approved by HealthAmerica’s QI Committee. The guidelines outline our expectations for medical record-keeping, as well as the performance goals for medical record audit. HealthAmerica encourages PCPs to review the medical record documentation guidelines that can be found on the HealthAmerica provider website, provider manual, or by request from your provider relations representative. [Click here to access the most recent medical records documentation standards](http://www.pamedsoc.org).

If you have any questions regarding this review, or information regarding any of our quality improvement activities including disease management, please call the Quality Improvement department at 717-526-2810.

Our QI department appreciates the physicians, office managers, and staff who took time to provide the records we needed.

Cardiologists and General Surgeons are Included in the HealthAmerica Continuity and Coordination of Care Audit

The purpose of the Continuity of Care audit is to assess the coordination of care across settings or transitions in care. In 2012, the Continuity of Care audit focused on the specialties of
cardiology, and general surgery. PCP charts of members who had a cardiology or general surgery specialty visit were reviewed for communication from the specialist about the specialty visit. Findings revealed the following:

- 59% of cardiologists communicated with the patient’s PCP
- 65% of general surgeons communicated with the patient’s PCP.

Specialists included in the audit will receive a letter with their score, and all cardiologists and general surgeons in the network will receive a letter reminding them to communicate with the patient’s PCP.

To ensure coordination of care, HealthAmerica and Advantra encourage our providers and members to work together to promote communication between specialists and primary care physicians. Please remember to send a consultation report to patients’ primary care physicians after each visit.

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**Human Chorionic Gonadotropin**

According to CMS policy, human chorionic gonadotropin (84702) is payable when billed with specific diagnoses. This code will be denied in the absence of one of the designated covered diagnoses identified in the NCD coding manual.

Based on CMS IOM 100.03, Chapter 1, Part 3, Section 190.27; Human Chorionic Gonadotropin (hCG) is useful for monitoring and diagnosis of germ cell neoplasms of the ovary, testis, mediastinum, retroperitoneum, and central nervous system. Additionally, hCG is useful for monitoring pregnant patients with vaginal bleeding, hypertension and/or suspected fetal loss.

It is not reasonable and necessary to perform hCG testing more than once per month for diagnostic purposes. It may be performed as needed for monitoring of patient progress and treatment. Qualitative hCG assays are not appropriate for medically managing patients with known or suspected germ cell neoplasms.

The list of the covered diagnoses for each lab procedure can be found at the following link: [http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/Downloads/manual201210.pdf](http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/Downloads/manual201210.pdf)

Procedure code 84702 (Gonadotropin, chorionic (hCG); quantitative) is performed to track the changes in values of hCG with the regards to the above conditions while 84703 (Gonadotropin, chorionic (hCG); qualitative) is used for the detection of hCG.

**For most pre-op testing and determination of pregnancy, 84703 is the appropriate test.**

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**CoventryCares of West Virginia Pharmacy Update**

Effective April 1, 2013, Coventry Cares of WV will be responsible for the pharmacy benefit currently managed by the Bureau for Medical Service for our Medicaid members. Express Scripts will be the Pharmacy Benefit Manager for the program.

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**Language Line Phone Interpretation Services**
For language translation services, members can the Customer Service phone number listed on the back of their ID cards. Translation services are available to all members enrolled in all products and states.

When non-English-speaking customers call Customer Service, we use in-house staff who speak the language if possible. If outside interpretation is needed, we use a translation service. Our service has interpreters for more than 140 languages, 24 hours a day, seven days a week.

Interpretation by phone is a quick and easy way to talk with someone who doesn't speak English. It helps us serve our members who have limited English-speaking skills. We can help our members get information about benefits and how to use medical services.

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**QI Confidentiality**

Privacy and health information is a very important topic for health plans, providers, and members. The law sets rules and limits on who can look at and receive a member’s information. Information can be used and shared:

- with the insurer for health care operations such as quality improvement activities
- to pay for health care
- to protect the public’s health, such as reporting information when the flu is in your area
- to make required reports to the police, such as reporting gunshot wounds
- with the member, on request

Health plans and providers are required to have a written privacy procedure, including a description of staff that has access to protected information, how it will be used, how it will be stored securely, and when it may be disclosed. In addition, all employees need to be trained on the privacy policies and procedures on a periodic basis.

When we conduct the yearly medical record review, the on-site audit tool includes a question on whether the office has a policy and conducts training with the staff on confidentiality. If the office does not have a policy in place, a recommendation is provided to the office to develop a confidentiality policy and procedure including secure storage of records, access to records only by authorized personnel, and employee training in privacy of member information. If the office has a policy in place but does not do annual training, a recommendation is provided to the office to provide an annual training program to all staff.

All our health plans have written policies for confidentiality. A copy of this policy can be obtained from your Provider Relations representative, on our websites, or in the provider manual. For more information on health care privacy information, visit [http://www.hhs.gov/ocr/privacy/index.html](http://www.hhs.gov/ocr/privacy/index.html), the U.S. Department of Health & Human Services website.

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## Provider Relations Representatives for Coventry Healthcare of West Virginia and CoventryCares of West Virginia

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Email Address</th>
<th>Region Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brumfield, Matilda</td>
<td>(304) 348-2018</td>
<td><a href="mailto:mjbrumfield@cvty.com">mjbrumfield@cvty.com</a></td>
<td>Southern WV region including Roane, Clay, Nicholas, and Pocahontas county and bordering KY counties.</td>
</tr>
<tr>
<td>Deguilmi, Anna Marie</td>
<td>(681) 285-9798</td>
<td><a href="mailto:amdeguilmi@cvty.com">amdeguilmi@cvty.com</a></td>
<td>Eastern Panhandle region, including bordering PA, MD counties.</td>
</tr>
<tr>
<td>Sentich, Lisa</td>
<td>(304) 234-3486</td>
<td><a href="mailto:lmoakes@cvty.com">lmoakes@cvty.com</a></td>
<td>Northern Panhandle and North Central WV, including bordering OH counties.</td>
</tr>
<tr>
<td>White, Sarah</td>
<td>(304) 348-2089</td>
<td><a href="mailto:sewhite@cvty.com">sewhite@cvty.com</a></td>
<td>Kanawha County region including surrounding counties, the Wood County region including surrounding counties in WV and OH, as well as Cabell, Wayne, and Putnam counties and bordering KY and OH counties.</td>
</tr>
</tbody>
</table>

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## Reinforce Your Patients’ Treatment Plans with Our Disease Management Programs

Coventry Health Care supports your patients who have asthma, diabetes, COPD, coronary artery disease and heart failure through our disease management programs. We identify members using claims, pharmacy data, health-risk appraisals, wellness information, self-referrals and referrals from providers and our utilization management processes. Eligible members are enrolled in the program but can opt out anytime.

Members receive a welcome phone call, an introductory letter and disease-specific action plan, educational mailings, and a variety of reminders about important health screenings, exams and immunizations. Our disease management staff calls members for one-on-one education if needed.

The programs reinforce your treatment plans, encourage patient self-management, emphasize the importance of compliance with recommended treatments, stress the benefit of a healthy lifestyle and encourage members to communicate with their physician.

To confirm that a member is in a disease management program, or to refer a member to a program, call our Disease Management call center at 1-800-579-5755.
Programs are tailored to the condition. They encourage members to do the following:

<table>
<thead>
<tr>
<th>Asthma</th>
<th>COPD</th>
<th>Diabetes</th>
<th>Heart Disease</th>
</tr>
</thead>
</table>
| ➢ Use a written action plan  
➢ Comply with prescribed medical treatments  
➢ Use a peak flow meter regularly  
➢ Identify and avoid asthma triggers  
➢ Get an annual influenza vaccination  
➢ Quit smoking | ➢ Have routine spirometry testing  
➢ Comply with prescribed medical treatments  
➢ Quit smoking  
➢ Get an annual influenza vaccination  
➢ Get a pneumonia vaccine | ➢ Get routine HbA1c testing  
➢ Get annual lipid profile and microalbumin testing  
➢ Have an annual dilated retinal exam  
➢ Get routine foot exams  
➢ Have blood pressure monitored routinely  
➢ Self-monitor blood glucose (as indicated)  
➢ Get an annual influenza vaccination  
➢ Quit smoking | ➢ Have routine lipid and BP monitoring  
➢ Comply with prescribed medical treatments  
➢ Follow a heart-healthy diet  
➢ Get regular physical activity (as indicated)  
➢ Track weight daily (for heart failure members)  
➢ Quit smoking  
➢ Get an annual influenza vaccination |

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**Where to Find the Formulary**

The most up-to-date formularies are available on our websites. To find the formulary by product type:


You can bookmark these links for future reference.
Need Help? Turn to our Websites.

www.chcde.com in Delaware and Maryland  
www.chcwv.com in West Virginia  
www.healthamerica.cvty.com in Pa. and Ohio

Click Providers then choose Document Library to learn more about the following:
- Access standards
- Confidentiality policy
- Pregnancy assessment form
- Practice safety assessment form
- CT scan worksheet
- New therapy progress worksheet
- Medical record review policy and guidelines
- Clinical Practice Guidelines (Provider)
  - ADHD
  - Asthma
  - Bipolar Disease
  - Heart Failure
  - Coronary Artery Disease
  - Depression
  - Diabetes
  - Osteoporosis (Adult)
- Clinical requirements, reference, and worksheets (for providers)
- Pharmacy forms (for providers)
- Right to correct credentialing information
- Information about our case and disease management programs
- CCM (complex case management) referral form

Click Plan Members then choose Other Important Information to learn more about the following:
- Submitting a claim form for covered services.
- Finding a network health care professional and information about him or her.
- Benefit restrictions and obtaining care and coverage when outside the system or service area.
- Obtaining care after normal office hours or emergency care.
- Receiving primary care, including points of access and pharmacy procedures.
- Reviewing the prescription drug formulary.
- Filing a complaint or appeal, including the availability of independent review.
- Information about our chronic disease and case management programs.
- Member rights and responsibilities.
- Notice of Privacy Practices.
- What utilization management is, how decisions are made, and how to contact the UM department.
- Standards our network providers must meet.
- Our quality and compliance efforts.
- Evaluation of new medical technology.
- Obtaining specialty, behavioral health or hospital care.
- Information about quality and patient safety.
- Preventive care guidelines, health appraisals and self-management tools.
- Benefits and services included in and excluded from coverage.
- Copayments and other charges for which members are responsible.
• How to obtain language assistance.
• Advance directives (“Living Wills”) for health care
• How to contact us
• Mental health and substance abuse

MHNet PCP Newsletter

If you do not have Internet access, call your Provider Relations representative to receive a copy of the newsletter or any of the documents on our website via U.S. mail.

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