June Informed Newsletter

June 11, 2019

As It Relates to You

Treating Insomnia

From John P. Beck, Health Alliance VP and Associate Chief Medical Officer and Sadie Sutter, Pharm.D.:

Insomnia is a common problem among patients, with nearly 30 percent of the general population reporting symptoms of sleep disruption. Older adults are at particular risk of insomnia on the basis of age-related changes in sleep physiology, with as many as 50 percent reporting insomnia.

A patient complaining of insomnia needs a thorough medical evaluation, as chronic insomnia may be associated with a variety of underlying medical, behavioral and environmental conditions and medication side effects.

Non-pharmacologic interventions, including use of cognitive behavioral therapy, should be considered first in the treatment of insomnia.

There are a variety of pharmacologic agents available for patients with insomnia. They may be particularly appropriate for acute insomnia, when immediate symptom relief is desired. **Some general recommendations include using the lowest effective dose, using on an intermittent basis (two to four times weekly) and prescribing for no more than three to four weeks.**

Agents to consider include the benzodiazepines, non-benzodiazepine Z-drugs, some antidepressant medications and medications that help regulate the body's natural sleep-wake cycle.

Insomnia is a frequent complaint brought to physicians by their patients. While the first step is a thorough evaluation, we have tried to present some of the treatment interventions and general guidelines for their use. Below is information on the tier status of the various medications and their costs to help in your decision-making.

	Medicare Part D (cost per 30 days)	Commercial
Temazepam	Tier 2 ($20)	Non-preferred generic
Zolpidem	Tier 2 ($20)	Non-preferred generic
Eszopiclone, zaleplon	Non-Formulary	Non-preferred generic
Belsomra (suvorexant)	Tier 3 ($47)	Non-preferred brand
Rozerem (ramelteon)	Tier 4 (~$260)	Non-preferred brand
Silenor (doxepin 3 mg, 6 mg	Tier 3 ($47)	Non-preferred brand

Code	Description	Comment
0760–0761 0769	Treatment Room	Bill with applicable HCPCS/CPT codes when a specific procedure has been performed or a treatment rendered.

HEDIS Adult BMI Measure Update

Adult BMI is a Health Effectiveness Data and Information Set (HEDIS) measure gathered on Medicare, Commercial and Marketplace plan members. The Adult BMI assessment is divided into categories by age:

- The percentage of members age 18–19 who had their height, weight and BMI documented during an outpatient visit
- The percentage of members 20–74 who had their weight and BMI documented during an outpatient visit.

Documentation can be dated in the current measurement year or the previous year. Documentation is very specific for this measure.

Members ages 18–19 must have their height, weight and BMI percentile recorded. Information can be from multiple sources but cannot be from different sources. For example, a weight and height measurement can't be combined with BMI percentile from a cardiologist's note.

Members 20–74 need a documented weight and BMI. These also need to be from the same source. The weight and BMI can be from different notes from the same provider source, however.

Barriers affecting this measure include patients in wheelchairs not weighed due to difficulty standing, and patients who haven’t been seen in the two-year time frame for this measure. Your office should contact members who haven’t been seen in the two-year time frame to schedule an appointment, as there are probably other measures that can be captured during their visit.

There are two reasons a patient can be excluded from this measure.

- A patient in hospice care during the current or previous year
- A woman who is pregnant during the two-year measurement period

Technical specifications for this measure are available in *HEDIS 2019, Volume 5* by the National Committee for Quality Assurance (NCQA).

2018 Adult BMI Rates

	HEDIS 2018	HEDIS 2017	HEDIS 2016	QC Nat Average	QC 75th Percentile	QC 90th Percentile
Commercial HMO/POS	94.56%	91.85%	88.05%	79.78%	89.29%	93.20%
Marketplace HMO	87.21%	85.33%	88.32%	79.78%	89.29%	93.20%
Marketplace POS	87.21%	89.29%	87.35%	79.78%	89.29%	93.20%
MA HMO/POS	95.13%	99.00%	98.05%	96.11%	98.78%	99.03%
Northwest MA HMO/POS	97.81%	94.00%	82.48%	96.11%	98.78%	99.03%
Midwest MA HMO	82.31	81.19%	62.79%	99.00%	99.00%	100.00%

HEDIS WCC Measure Update

Weight Assessment and Counselling for Nutrition and Physical Activity for Children/Adolescents (WCC) is a HEDIS measure gathered on Commercial and Marketplace plan members. It assesses the percentage of members age 3–17 years old who had:

- An outpatient visit with a PCP or OB/GYN
- Evidence of BMI percentile documentation
- Counseling for physical activity and nutrition

To satisfy this measure, the patient needs an office visit with their BMI percentile documented, which can be on an age growth chart for adolescents 3–16 years of age. For adolescents 16–17, the BMI value (kg/m^2) is used. Counseling for nutrition and for physical activity must be completed with proper documentation. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

Documentation is very specific for this measure and is allowed from any type of visit, not only a well-child visits. Documentation related to member's "appetite" or being "well nourished" does not meet criteria for counseling for nutrition; likewise, a note of "health education" or "anticipatory guidance" without specific mention of current nutrition and exercise discussion/plan with patient also does not meet criteria. A note of "cleared for gym class" or "health education" without specific mention of physical activity also does not meet criteria.

Examples of good encounter and documentation include:

- "Discussed with patient and parent the importance of good eating habits and healthy dieting behaviors."
- "Discussed the benefits of exercise and participating in sports."

Female members who have a diagnosis of pregnancy during the measurement year are excluded from this measure. Technical specifications for this measure are available in *HEDIS 2019, Volume 5* by the National Committee for Quality Assurance (NCQA).

WCC 2018 Rates

	Commercial HMO/POS	Marketplace HMO	Marketplace POS	QC Nat Average	QC 75th Percentile	QC 90th Percentile
BMI Percentile	**80.79%**	**77.37%**	**75.67%**	70.59%	81.97%	88.08%
Counseling for Nutrition	**67.89%**	**63.02%**	**54.50%**	65.50%	75.08%	83.21%
Counselling for Phys. Act	**62.63%**	**60.10%**	**48.91%**	59.96%	70.26%	77.32%

Coding Reminders

Both the Medicare Advantage and commercial Marketplace condition category models are dependent on us receiving accurate diagnosis codes through claims submission. All claims submitted to us must have associated diagnosis codes. There are two areas of opportunity we need your assistance in addressing:

- Code truncation, or systems limits on the number of diagnosis codes per claim submission
- Claims that are not submitted at all (e.g., claims for capitated, custodial care, etc.)

These scenarios leave gaps in accurate reflections of the overall risk of the population and may inadvertently omit members from being included in care management programs directed at assisting with health outcomes for their chronic conditions. Please assess your billing practices at an organizational and provider level to ensure these situations don't apply to you.

If you identify these issues or have concerns that the above applies to your system, contact us at CodingCounts@healthalliance.org, and we'll reach out to help with a solution.

For useful information on documentation and code reporting, subscribe to our coding e-newsletter.

Requests for Coding Review

When reviewing a coding denial, please refer to the Provider Remittance Advice (PRA) to see the code edit message, which gives a more detailed description of the denial.

We've found that many providers are only looking at the CARC/RARC reason codes on the Explanation of Benefits, which does not go into specific details of the denial. Please use the PRA to make the review process easier for everyone involved.

Submit Entire Corrected Claim for Reprocessing

When submitting a corrected claim, please send in an entire corrected claim for the services rendered on that day. Some providers are submitting partial corrected claims containing only the new detail to be corrected. We need a whole new account of **all** services rendered during that encounter to replace the entire original submission.

Also, if billing on a HCFA 1500 form, use frequency code 7. If billing on a UB form, bill with a UB bill type ending in 7. This will let us know the claim is a corrected claim.

Blood Pressure Screening Reminders and Tips

Hypertension is the most common reason for a person with any chronic condition to visit a clinician. It is a major risk factor for heart disease, stroke and kidney disease. Even small increases in blood pressure raise the risk for cardiovascular disease and mortality. The risk of death from ischemic heart disease and stroke doubles for every 20 mmHg increase in systolic blood pressure or 10 mmHg increase in diastolic blood pressure.

Hypertension affects almost one-third of American adults ages18 or older (72 million people) and is uncontrolled in nearly half of those (35 million people). This population with uncontrolled hypertension represents a large pool of patients for whom clinicians could consider further clinical intervention.

Provide both initial and ongoing training to staff to ensure that blood pressure readings are taken correctly. Make sure that readings are communicated and that elevated blood pressures are reassessed.

- Encourage staff to assess whether patients have used nicotine or caffeine, have exercised in the last 30 minutes or have a full bladder. Have patient sit in a chair with feet on the floor and arm supported so that the elbow is at about heart level. The inflatable part of the cuff should completely cover at least 80 percent of the upper arm. The cuff should be placed on bare skin, not over a shirt. Remove any tight-sleeved clothing.

- Encourage patients to monitor their blood pressure at home. Remember to ask patients to bring their home blood pressure cuff into your office for calibration. Educate them on their blood pressure goals as well as when to report their readings.
- Consider non-pharmacological treatments in addition to medications. Encourage patients to lead a healthier lifestyle including weight loss, reducing sodium intake and increasing physical activity.
- Stress the importance of medication adherence to your patients. Consider prescribing a statin medication as well.
- Encourage patients to participate in health coaching or care coordination. You may place an order for health coaching by using "Amb health coach." Our members may also call 1-800-851-3379, extension 28947, weekdays 8 a.m.–5 p.m. CT to sign up for these services.

To learn more, review this information from the CDC's Division for Heart Disease and Stroke Prevention.

Colorectal Cancer Screening Reminder

Colorectal cancer is the second-leading cause of cancer-related death in the U.S. Colorectal cancer is 90 percent preventable and 90 percent treatable when detected early enough. One in three adults over the age of 50 is not up to date on colorectal cancer screening. Talk with your patients about colorectal cancer screening options.

Available colorectal cancer screenings methods include:

- Fecal occult blood test (gFOBT) annually
- FIT (fecal immunochemical test) annually
- Cologuard every three years
- Flexible sigmoidoscopy every five years
- Colonoscopy every 10 years

Whichever screening method our members choose, most of our plans cover it at 100 percent. If additional testing or related services are needed, a copay or coinsurance may apply. To check for exact coverage, members should call the Customer Service number on the back of their ID cards.

Pharmacy Updates

All Plans

Formulary Additions

Gastroenterology

- Doptelet (avatrombopag)
  - Indicated for the treatment of thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure
  - Formulary placement:
    - Commercial—Non-Preferred/Non-Formulary Specialty with preauthorization (PA)
    - Medicare—Tier 5 with PA
- Mulpleta (lusutrombopag)
  - Indicated for the treatment of thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure
  - Formulary placement:
    - Commercial—Non-Preferred/Non-Formulary Specialty with PA
    - Medicare—Tier 5 with PA
- Motegrity (prucalopride)
  - Indicated for the treatment of chronic idiopathic constipation in adults
  - Formulary placement:
    - Commercial—Non-Preferred Brand with QL #30/30 days
    - Medicare—Non-Formulary

Endocrinology

- Orilissa (elagolix)
  - Indicated for management of moderate to severe pain associated with endometriosis
  - Formulary placement:
    - Commercial—Non-Preferred Brand with PA
    - Medicare—Non-Formulary

Commercial

Criteria Changes

Gastroenterology

- Xifaxan

    - Removed neomycin and metronidazole from step requirements for hepatic encephalopathy, leaving only lactulose

Endocrinology

- Diabetes Drug Therapies
    - Removed sulfonylureas (SUs) from step-therapy criteria for 2nd-line antihyperglycemic drugs
    - Added insulin to electronic step-therapy criteria for preferred 2nd-line antihyperglycemic drugs
    - Non-Preferred insulin: Added requirement of previous trial with one Preferred insulin
- Testosterone
    - Removed attestation requirement regarding initial treatment range
    - Updated reauthorization of Testopel to allow for up to four procedures per year
- Supprelin LA
    - Added criteria for gender dysphoria

Formulary/Tier Changes

- Ozempic—moved from Non-Preferred Brand to Preferred Brand

Medicare

Criteria Changes

Endocrinology

- Diabetes drugs
    - Added insulin to step therapy criteria for Preferred 2nd-line antihyperglycemic drugs

Tier Changes

- Ventolin and ProAir—Tier 3 to Tier 2
- Silenor—Tier 4 to Tier 3
- Humulin N, R vials—Tier 2 to Tier 1 with QL
- Chantix—Tier 4 to Tier 3

2019 Formulary Additions

- Lonhala Magnair, a nebulized version of Seebri—Tier 4
- Olmesartan and olmesartan HCT—Tier 2
- Dutasteride—Tier 2
- These drugs no longer hit the High-Risk Medication display measure:

    - Armour Thyroid—Tier 4
    - NP Thyroid—Tier 2
    - Digoxin 0.25 mg—Tier 2
    - Estrogen tablets/patches—Tier 2
    - Premarin/Prempro—Tier 4

2020 Formulary Removals

- Repatha and Praluent high-cost NDCs

2020 Quantity Limits

- Doxepin cream and lidocaine cream & ointment—smallest package size QL

2019 PA Removal

- Estradiol 2 mg
    - Other estrogens are being added at Tier 2 with no PA