

# NETWORK NEWS

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*To be the  
healthcare  
choice of the  
communities  
we serve.*

## Easy to do Business With

*At Optima Health, we are continuously looking for ways to make our health plan better and build our reputation as easy to do business with. The following are a few ways we feel we are "Making it Easier, Making it Better" for providers:*

**Making it  
*Easier.*  
Making it Better.**

Optima Health has exciting news regarding Health Maintenance Organization (HMO) and Point-of-Service (POS) plan members!

Effective January 1, 2008, many of our groups will be transitioning to referral-less plans in which referrals to see a participating specialist are no longer required!

Members will still need to select a PCP to coordinate their care and guide their decisions, but are not required to obtain a referral prior to seeing a participating specialist. Requirements for prior authorization are not affected by this change.

New Optima ID cards for affected members will display the words "No Referral Required" to make it clear that their plan is now referral-less.

Groups still requiring referrals to see a specialist are Virginia Beach City and Schools, Bank of America, Raytheon and Colonial Williamsburg.

If you have any questions regarding this enhancement, please contact your Optima Health Network Educator.

Individual Product		No Referral Required	
Member Name: JOHN SAMPLE		Copays	OV: \$25
Member #: 1999995*01			SOV: \$50
Member Eff. Date: 07-01-05	Group Number: 10000		IP*: 70/30
Benefit Eff. Date: 07-01-05			OP: 70/30
PCP: DR DOCTOR	Plan: 1000		Dx1: 70/30
PCP Phone #: 999-9999			Dx2: 70/30
			ER: 70/30
Member Services: 757 552-8850 or 800 741-9910	After Hours Nurse Triage: 757-552-7250 or 1-800-394-2237		LIC: \$50
	www.optimahealth.com		Rx: \$10/30/50/75
			Rx Ded.: \$50
			Coins: NA

Offered by Optima Health Plan

ID.01.08

*This section is dedicated to providing the most up-to-date Optima Health coding and billing information. Please contact our Provider Relations department with questions.*

**Advanced Imaging Coding Changes for 2008.**



**New Codes in 2008**

**7. Heart**

- a. MRI/no contrast 75557
- b. MRI flow quantification 75558
- c. MRI with stress imaging 75559
- d. MRI quantification/stress 75560
- e. MRI/both sequencing 75561
- f. MRI/flow sequencing 75562
- g. MRI/stress sequencing 75563

**Deleted Codes in 2008**

**7. Heart**

- a. MRI/no contrast 75552
- b. MRI/contrast 75553
- c. MRI/both 75554
- d. MRI/limited 75555
- e. MRI/mapping 75556

For the complete Advanced Diagnostic Imaging MRI-MRA Pre-Certification form, visit [www.optimahealth.com](http://www.optimahealth.com)

**Physician In-Office Lab List Update**

Effective October 1, 2007, the physician in-office lab list has been revised to include CPT code 86308 - Heterophile antibodies;screening.

Please visit the provider section of [optimahealth.com](http://optimahealth.com) for the most current and complete physician in-office lab listing.

**HEDIS® Review Begins in February 2008**

The Quality Improvement Department would like to thank the physicians and office staff for their assistance with our annual HEDIS® 2007 data collection and medical record review. We appreciate your assistance with this important quality initiative.

Once again, we found that the information contained in your records enhanced the data gathered from our claims department. The combination of this information better reflects the actual service our members received from your office. The annual review of this information also assists us in determining whether or not our quality improvement efforts, i.e., immunizations, cervical and mammogram reminder systems, have helped to improve with the number of our members seeking preventive care. The collection of HEDIS data is also a part of our NCQA (National Committee for Quality Assurance) accreditation process.

HEDIS® 2008 measures are available on the provider web site at [www.optimahealth.com](http://www.optimahealth.com). For paper copies, please contact the Quality Improvement Department at 757-552-7350 or 1-866-425-5257

# Pharmacy Changes

*Applies to plans with pharmacy benefits administered by Optima Health*

*The purpose of the following is to communicate pharmacy changes effective January 1, 2008:*



*Note\* Pharmacy changes are now made on a quarterly basis with effective dates of :  
January 1st, April 1st, July 1st, and October 1st.*

*(Concerta is the Optima Health Preferred Long-Acting Stimulant. It is available at tier 3 without restrictions. Family Care members must try and fail one short-acting stimulant prior to using Concerta)*

<b>Drug Name</b>	<b>Purpose</b>	<b>Tier* Effective 10/1/07</b>	<b>Change Effective 1/1/08</b>	<b>Alternatives</b>
Vyvanse	Used in the treatment of Attention Deficit Hyperactivity Disorder (ADHD)	Tier 4 (currently Tier 4)	Will remain at tier 4 and require step-therapy for all <i>new</i> prescriptions filled after January 1 <sup>st</sup> . Must have tried and failed Concerta.	Adderall – Tier 1 Ritalin – Tier 1 Dexedrine – Tier 1
Adderall XR	Used in the treatment of Attention Deficit Hyperactivity Disorder (ADHD)	Tier 3 (currently Tier 3)	Will remain at tier 3 and require step-therapy for all <i>new</i> prescriptions filled after January 1 <sup>st</sup> . Must have tried and failed Concerta.	Adderall – Tier 1 Ritalin – Tier 1 Dexedrine – Tier 1
Ritalin LA	Used in the treatment of Attention Deficit Hyperactivity Disorder (ADHD)	Tier 3 (currently Tier 3)	Will remain at tier 3 and require step-therapy for all <i>new</i> prescriptions filled after January 1 <sup>st</sup> . Must have tried and failed Concerta.	Adderall – Tier 1 Ritalin – Tier 1 Dexedrine – Tier 1
Focalin XR	Used in the treatment of Attention Deficit Hyperactivity Disorder (ADHD)	Tier 3 (currently Tier 3)	Will remain at tier 3 and require step-therapy for all <i>new</i> prescriptions filled after January 1 <sup>st</sup> . Must have tried and failed Concerta.	Adderall – Tier 1 Ritalin – Tier 1 Dexedrine – Tier 1
Daytrana	Used in the treatment of Attention Deficit Hyperactivity Disorder (ADHD)	Tier 4 Currently Tier 4)	Will remain at tier 4 and require step-therapy for all <i>new</i> prescriptions filled after January 1 <sup>st</sup> . Must have tried and failed Concerta.	Adderall – Tier 1 Ritalin – Tier 1 Dexedrine – Tier 1
Metadate CD	Used in the treatment of Attention Deficit Hyperactivity Disorder (ADHD)	Tier 3 (currently Tier 3)	Will remain at tier 3 and require step-therapy for all <i>new</i> prescriptions filled after January 1 <sup>st</sup> . Must have tried and failed Concerta.	Adderall – Tier 1 Ritalin – Tier 1 Dexedrine – Tier 1

*\*For Groups without a Four-Tier pharmacy plan, drugs listed as moving to tier 4 will remain at tier 3.*

- ❖ *Torisel, used in the treatment of advanced renal cell carcinoma, requires prior authorization. Torisel falls under the medical benefit and is restricted to the FDA approved indications.*
- ❖ *Prior Authorization/Step Therapy forms will be available through the Provider Portal of [optimahealth.com](http://optimahealth.com) on January , 2008*

*If you have questions or comments regarding these changes, please contact your Optima Health Network Educator.*

## Pharmacy Reporting

The Pharmacy Department developed several new provider reports over the summer. These reports are aimed at improving member safety, quality of care, and assisting with the coordination of care among providers.

The report packets will be mailed containing the following:

- 1) Information about the report, including medical literature references.
- 2) A summary list of patients.
- 3) Individual patient report sheets for placement in the medical record.

Based on pharmacy claims data and generated on a quarterly basis, reporting will provide information on:

- Patients who have filled 3 or more narcotic prescriptions, written by 4 or more physicians during a 3 month period.
- Patients with simultaneous use of 2 or more benzodiazepines during a 3 month period.
- Patients on 2 or more atypical antipsychotics for more than 60 days during a 3 month period.
- Patients age 14 or older prescribed Seroquel at a dose of 50mg or less per day.

As always, it is our goal to provide you with accurate and useful information. We welcome your feedback regarding these reports. Please feel free to contact the Pharmacy Department at 757-552-7540 (option 4, then option 6) or 800-229-5522 (option 4, then option 6).

## Medication Safety

### High-Risk Medications in the Elderly

With an expanding focus on patient safety, the Healthcare Effectiveness Data and Information Set (HEDIS®) measure "High Risk Medications in the Elderly" targets the safe use of medications in patients 65 and older. The medications on the list are based on the Beer's list, the recognized consensus standards for medication use in older adults. These medications have been determined to be harmful in older adults, regardless of medication dose, frequency, or patient's underlying health condition. A copy of this medication list can be found on the Provider website, [www.optimahealth.com](http://www.optimahealth.com), under Provider Resources or by contacting the Quality Improvement Department at 757-552-7350 or 1-866-425-5257.

### Free Medication Wallet Cards

Free medication wallet cards are available to help your patients keep track of the medications they take, use their prescription medications safely, and partner more effectively with their physician. Your patients can obtain medication wallet cards by: calling 1-800-SENTARA or accessing the Sentara website at [www.sentara.com](http://www.sentara.com).

## Quality Improvement Highlights

Optima Health annually collects Healthcare Effectiveness Data Information Set (HEDIS®) data for our members. Optima Health works hard to improve these rates by sharing this information with our providers. HEDIS® reporting provides a measurement tool that holds us accountable and provides focus for better service to all our customers, as well as facilitating improved care for our members.

Listed below are our HEDIS® 2007 rates based on CY 2006 data:

HEDIS ® 2006 Measures	Commercial		Medicaid	
	CY2005	CY2006	CY2005	CY2006
Childhood Immunization	88.64%	88.6%	70.18%	70.1%
Adolescent Immunization	52.85%	59.2%	40.45%	46.9%
Breast Cancer Screening*	74.54%	70.5%	58.55%	51.7%
Cervical Cancer Screening *	85.50%	79.7%	64.74%	60.1%
Timeliness of Prenatal Care	93.31%	94.1%	84.01%	90.2%
Postpartum Visit	84.99%	81.3%	59.31%	61.9%
Dilated Eye Exam (Diabetes)	49.35%	49.1%	45.05%	42.1%
Controlling High Blood Pressure *	72.69%	61.7%	63.38%	59.8%
Colorectal Cancer Screening	68.02%	70.4%	42.50%	43.1%

\*Breast cancer screening new age range 42-69

\*Cervical cancer screening new age range 24-64

\*Controlling high blood pressure new age range 18-85

For more information about Quality Improvement at Sentara Health Plan Inc. please contact the Quality Improvement Department at 757-552-7350. For more information regarding NCQA visit the web site at [www.ncqa.org](http://www.ncqa.org).

## Quality Improvement Earns “Excellent” NCQA Rating

Once again, Optima Health has earned the highest possible rating of "Excellent" from the National Committee for Quality Assurance (NCQA) for our HMO/POS and Medicaid products. Optima Health offers a comprehensive quality improvement program providing a foundation for the development of programs and activities directed towards improving the quality of health care and services for our members.



The QI program is designed to implement, monitor, evaluate and improve processes that are within the scope of the Health Plan. Feedback from our members and providers is important, as it helps us to determine opportunities for improvement. Optima Health Quality Improvement coordinates the review and distribution of clinical guidelines for our practitioner network, credentials and re-credentials our network of providers, conducts medical record reviews, and monitors and evaluates the continuity and coordination of care between primary care physicians and specialists including behavioral health practitioners.

## 2007 Medical Record Audit Identifies Strengths and Improvement Opportunities

Complete and consistent documentation in patient medical records is an important component of quality patient care. As part of the annual Healthcare Effectiveness Data and Information Set (HEDIS®) audit this past spring, a random sample of medical records was reviewed for specific compliance with medical record documentation standards.

### Identified areas of strength:

- A current and complete problem list is provided.
- Prescribed medication, including dosages and dates of initial or refill prescriptions are recorded.
- Comprehensive past medical history is included in records.
- Working diagnosis is consistent with findings.
- Plan of treatment is consistent with findings.
- Care appears to be medically appropriate based on documentation.

### Identified areas for improvement:

- Documentation of Advance Directive\*
- Documentation of Adverse Reaction to Medication
- Documentation of Continuity and Coordination of Care with Specialists
- Documentation of Continuity and Coordination of Care with Behavioral Health Practitioners

### New or Continued Areas of Focus for the 2008 Medical Record Documentation Standards

- Documentation of BMI calculation in children
- Documentation of physician inquiry about nutrition and physical activity during well child visits.
- Documentation of management plan or goal for children who are classified as overweight or at risk for overweight.

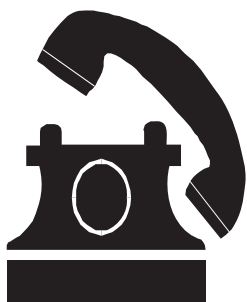
\*You may direct your patients to [www.sentara.com/Sentara/Patient/VisitorInfo/AdvanceDirective/](http://www.sentara.com/Sentara/Patient/VisitorInfo/AdvanceDirective/) for more information about advance directives and downloadable copies of advance directive forms.

## Pre-certification Update

To assist with the quality, safety, and medical appropriateness of advanced diagnostic imaging services, two more groups are adopting this program. Starting with requests on January 1, 2008, the Optima Federal Employee Plans and Optima Medicare will be included in the Pre-certification program for advanced imaging studies.

This program includes **elective advanced diagnostic image services; it does not include inpatient or emergency room studies.** Pre-certification is required for elective advanced diagnostic studies to be performed on or after **January 1, 2008.**

The list of services requiring pre-certification includes:



- CT (Computed Tomography) scans
- CTA (Computed Tomographic Angiography) including cardiac CTA
- MRI (Magnetic Resonance Imaging)
- MRA (Magnetic Resonance Angiography)
- MRS (Magnetic Resonance Spectroscopy)
- PET (Positron Emission Tomography)

The pre-certification telephone lines are:  
Phone: (757) 552-7540 or (800) 229-5522  
Fax: (757) 552-7429 or (877) 800-2839

# Spending Too Much On Medicare Coverage?

## Introducing Two New \$0 Premium Options

Annual Election Period – November 15-December 31

To receive an Enrollment Kit or learn about free Medicare meetings, call toll-free 1-888-443-9131 (TTY users 1-800-225-7784), 8 a.m.- 8 p.m., seven days a week. Or visit [www.optimahealth.com/medicare](http://www.optimahealth.com/medicare).

**OptimaHealth** 

*Optima Medicare plans are Medicare Advantage plans with a Medicare contract.*

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## Optima Health Reminders & Updates



**Optimahealth.com** - Look for these features on the web at [www.optimahealth.com](http://www.optimahealth.com)

- Clinical Practice Guidelines
- Member Rights and Responsibilities
- Medical Record Standards
- Preventive Health Guidelines
- Advance Directives
- HEDIS 2008



**Physician Satisfaction Survey** - As you know, Optima conducts an annual Physician Satisfaction Survey and we have begun the survey process for this year. This year Optima integrated the Behavioral Health survey into the medical survey as well as increasing the sample size. We use this survey to determine our strengths as well as the areas you would like us to improve upon. If you receive a survey, please take the time to fill it out and thank you in advance.



### **Optima Health Guidelines Updated!**

Many of Optima Health's clinical guidelines (e.g. Hypertension, UTI, VURI, and Health Maintenance) have been reviewed, updated, and are now available online. Our treatment guidelines are based on published national guidelines, literature review, clinical experience and reflect the current recommendation for screening, diagnostic testing, and treatment. For a more in-depth look at the guidelines, please refer to [www.optimahealth.com](http://www.optimahealth.com) in the Provider section under Do You Need To: View and Download Clinical Guidelines. CD's will be mailed at a later date.



### **CAHPS/Member Satisfaction**

The annual member satisfaction survey is conducted yearly March through May. Based on our member responses areas of concern are: Getting Care Quickly, How well their doctors communicate, and overall satisfaction with physician. We realize these areas are subjective, but Optima asks that you keep these areas in mind when seeing patients. We welcome your suggestions on how we can work together to positively change these results.

We would love the opportunity to answer any questions you may have for us. Please email your questions to [ProviderRelations@sentara.com](mailto:ProviderRelations@sentara.com) and we will try to answer them in the next edition of Network News.



# Optima Family Care Member Rights and Responsibilities

The Member Bill of Rights and Responsibilities assures that all members are treated in a manner consistent with the Plan's mission, goals and objectives and assures that members are aware of their obligations and responsibilities upon joining the Plan and throughout their membership with the Plan.

## **Members have the Right to:**

1. Be treated in a manner reflecting respect for your privacy and dignity as a person. While receiving health care services, there will be no discrimination based on race, ethnicity, national origin, religion, sex, age and mental or physical disability.
2. Be informed regarding your diagnosis, treatment and prognosis in terms you can reasonably be expected to understand.
3. Receive sufficient information to enable you to give informed consent prior to the initiation of any procedure and/or treatment.
4. Participate with practitioners in decision-making about your healthcare and refuse treatment to the extent permitted by law, and to be made aware of the potential medical consequences of such action.
5. A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
6. Expect that all communications and records pertaining to your health care will be treated as confidential. Any data shared is not member identifiable unless specific consent has been obtained. No records will be released without your written authorization to protect access to your medical information. In the case of a minor, release of information is allowed only by the authorization of the legal guardian or court order.
7. Select a primary care physician and expect the physician to provide, arrange for, and coordinate, all care you require.
8. Express complaints or appeals about the Plan or the care provided and, expect a response to that complaint or appeal within a reasonable period of time.
9. Reasonable access to necessary medical services.
10. Be informed of the Plan's policies and procedures regarding services, benefits, practitioners and providers, and member rights and responsibilities, and be notified of any significant changes in those policies and procedures. Upon request receive a copy of the Plan's Practice Guidelines.
11. Discuss your medical record with your physician, and to receive upon request a copy of that record as required under State Law and request that the record be amended or corrected. The Plan's staff can only release records with your physician's approval and your signed consent.
12. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
13. Obtain from the Plan information on how providers are paid. The MCO is prohibited from providing incentives for denials, limiting or discontinuing medical services.

## **Rights Continued:**

14. Make recommendations regarding member rights and responsibilities.
15. Freedom to exercise your member rights and expect that you will not be negatively affected by the Plan and its providers by exercising those rights.

## **Members have the Responsibility to:**

1. Work with the primary care physician to help establish the proper patient/physician relationship.
2. Schedule appointments and arrive on time for those appointments, or notify the primary care physician's office if the member/patient must cancel or come late for a scheduled appointment. Charges for missed appointments are not covered by the Plan.
3. Meet the financial obligations regarding copays when services are rendered. (FAMIS)
4. Ask any questions and understand the answers about the illness and/or treatment.
5. Obtain prior authorization from the primary care physician/physician before seeking consultation or other medical services, except in potentially life-threatening situations.
6. Obtain and carefully consider all information necessary to give informed consent for a procedure or treatment.
7. Weigh the potential consequences of any refusal to comply with physician instructions or recommendations.
8. Be courteous, considerate and cooperative in dealing with the PCPs, their office staffs and employees of the Plan, and to respect the rights of fellow Plan members.
9. Express opinions, concerns or complaints in a constructive manner to avoid similar problems in the future.
10. Read and be aware of all material distributed by the Plan explaining policies and procedures regarding services and benefits, and to follow those policies and procedures when receiving care.
11. To the extent possible, provide the Plan and providers with complete and accurate information necessary to care for the member, and for the member/patient's medical record and Plan membership records. This includes notifying the Plan of any changes in status such as phone number, address, and number of dependents (e.g., birth, marriage, divorce, etc.) and information regarding other health insurance coverage for coordination of benefit purposes.
12. Assist the Plan in compiling a complete medical record by providing or by authorizing the Plan to obtain necessary medical information. It is the member/patient's ultimate responsibility to furnish the Plan with any medical records needed to process a complaint, grievance or appeal of a denied claim when the Plan has been unable to obtain this information.
13. Follow the plans and instructions for care that they have agreed upon with their practitioners.

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# NETWORK NEWS

**Optima Health Marketing & Communications**  
4417 Corporation Lane  
Virginia Beach, VA 23462

## ATTENTION: PHYSICIANS AND STAFF

### Important Phone Numbers

Provider Relations Office	757-552-7474 or 800-229-8822
Provider Relations Fax	757-552-7316
Medical Care Services Office	757-552-7540 or 800-229-5522
Medical Care Services Fax	757-552-7429 or 877-800-2839
Referral Center Office	757-552-8911 or 877-800-2838
Referral Center Fax	757-552-8868 or 888-902-3456
Network Educators	757-552-7085 or 877-865-9075
PharmaCare Specialty Pharmacy	888-766-5495
PharmaCare Specialty Pharmacy Fax	877-278-0764
Sentara Behavioral Health Services Provider Relations	757-687-6297 or 877-687-6297
Sentara Health & Preventive Services	757-687-6000



**From Everyone at Optima Health:  
Have a wonderful Holiday Season!**

Any policy changes communicated in this newsletter are considered official and will be reflected in the next edition of the *Provider Relations Manual*.