Provider Report™

Going Green: Reducing Paper Claims

In an effort to go green, Sunshine State Health Plan (Sunshine Health) is urging its providers to submit all claims electronically, either over the Sunshine Health Web portal or with EDI. In addition to environmental benefits, providers will also realize the following benefits:

- Claims paid faster and more accurately than paper claims.
- Reduced postage and paper costs.
- More efficient and productive submission process.
- Cleaner data submissions results in fewer claims denials.
- Faster acknowledgement of received claims.

There are two options for electronic submissions: EDI and the Sunshine Health Web portal. Please contact your plan representative to help you determine which option is best for you.

If you are ready to get started, you will find a list of our associated EDI trading partners at sunshinestatehealth.com or you may call 1-800-225-2573, ext. 25525 to speak with someone at our EDI Help Desk. You can also begin the Web registration process when you visit our website. Our staff can help you get set up for electronic submissions, help you choose a clearinghouse and answer any other questions about this process. For additional information about submitting claims via our website, please register at our website or contact your Provider Relations Representative.

Targeting Smokers

CDC issues new recommendation for the pneumonia vaccine.

Good news about smoking? Just this: After a three-year plateau, the percentage of the U.S. population that smokes dropped below 20 percent in 2007, the lowest figure on record, according to new government figures. That's progress, but smoking-related illnesses continue to be a serious health problem.

In addition to higher risks of asthma, lung cancer, emphysema and cardiovascular disease, smokers have an increased risk of infections from the pneumonia-causing bacterium *Streptococcus pneumoniae*. Compared with nonsmokers, light smokers are twice as likely to get pneumonia, and people smoking 15 to 24 cigarettes per day have a fourfold risk.

The Centers for Disease Control and Prevention (CDC) reports that smokers account for about half of otherwise healthy adults with invasive pneumococcal disease. Based on such findings, a CDC vaccination advisory panel now recommends that all adult smokers (age 19 and older) get the pneumonia vaccine, which protects against 23 types of the bacterium. Nationwide, there are an estimated 31 million adult smokers. This is the first time smokers have been specified for a vaccine. The vaccine continues to be recommended for adults age 65 and older and those with long-term health conditions or lowered resistance to infection.

Smokers getting the vaccine should also be offered smoking cessation counseling, the panel advises. If smokers follow through and kick the habit, it would be a real shot in the arm for improved health.

An added reason to promote the pneumococcal vaccine, and not just to smokers, is that it's associated with a 50 percent lower risk of heart attack, with the protective effect strengthening over time, based on findings of a study of hospital-based, high-risk patients published in the *Canadian Medical Association Journal.*

2 Diabetes Treatment Guidelines Revised
3 Get the Facts About Advance Directives
4 Helping Patients in Hard Economic Times

Update for Type 2 Diabetes Treatment

Learn about revisions to the 3-step treatment approach.

For patients newly diagnosed with Type 2 diabetes, the goal is to get their glycemic level to as close a normal range as soon as possible and maintain it. Treatment **step one** is a combination of lifestyle changes (weight loss and increased physical activity), plus the drug metformin.

The next step, which involves adding a second medication for patients whose glycemic goals aren't reached within three months, is where new guidelines differ from earlier versions. According to the authors of the update, issued in December 2008 by the American Diabetes Association and the European Association for the Study of Diabetes, their revision focuses "on the new classes of medications that now have more clinical data and experience."

The preferred protocol in **step two** is the addition of insulin (intermediate- or long-acting) or sulfonylurea. This step is preferred because it's well-validated; both drugs having a long-term record of effectiveness and safety. A less-validated option is the addition of pioglitazone (brand name Actos) or exenatide (brand name Byetta). The new guidelines removed rosiglitazone (brand name Avandia) from the list of recommended drugs, citing evidence of potential cardiovascular risks associated with the drug.

In **step three**, if the first two steps don't get blood glucose to target levels, start insulin if you haven't already or increase it to a more intensive level—in addition to continuing lifestyle intervention plus metformin.

The Web address for accessing the updated guidelines is care.diabetesjournals.org/cgi/reprint/dc08-9025v1.

Don't Overlook The Obvious

In case you had any doubts, diabetes is in "surge" mode. Consider the near doubling of age-adjusted annual incidents of newly diagnosed diabetes in the past 10 years, according to CDC data:

- 4.8 adults per 1,000 (1995 to 1997).
- 9.1 adults per 1,000 (2005 to 2007).

In the U.S., population increases in diabetes have coincided with increases in obesity, so you might think that primary care providers would pay particular attention to the underlying risk of diabetes in obese patients. But a new study published in *Diabetes Care* reports that being obese hasn't improved a person's odds of having his or her diabetes diagnosed.

Researchers analyzed 5,514 individuals participating in the 1999–2004 National Health and Nutrition Examination Survey to determine the impact of body mass index on the likelihood of having undiagnosed diabetes. Of the 10 percent of individuals found to have diabetes, 28 percent hadn't been diagnosed. BMI made no difference, statistically speaking, in the proportion undiagnosed. Still, obese people accounted for more than half of the total number of undiagnosed diabetics.

The message for primary care providers is to not overlook the higher risk of diabetes among the obese when deciding whether or not to screen for the disease.

Talk About STIs

The U.S. Preventive Services Task Force now recommends high-intensity counseling for primary care patients at high risk for sexually transmitted infections (STIs). Those at high risk include all sexually active adolescents, adults with a history of STIs within the past year and adults with multiple sex partners.

Based on a review of studies, the task force found evidence suggesting a modest reduction in STIs, increased use of contraceptives among male adolescents and decreased nonsexual risky behavior and pregnancy in sexually active female adolescents.

Assessing patients for STI risks dovetails with encouraging them to be tested for HIV. Routine HIV testing of all patients older than age 13 is recommended in clinical guidelines recently issued by the American College of Physicians. Earlier USPSTF guidelines recommend screening of adolescents and adults if they have HIV risk factors.

Don't hesitate to address STIs with older patients, who may be re-entering the dating world after divorce or the death of a spouse. Vaginal changes in postmenopausal women may put them at increased risk for HIV transmission and other STIs. The Centers for Disease Control and Prevention reports that 15 percent of new HIV infections occur in the over-50 age group. Use counseling to raise awareness and teach protection.

Advance Directives

What you need to know about these important patient documents.

Advance directives are instructions given by persons to direct their healthcare in the event that they lose the ability to make and communicate medical decisions for themselves. The purpose of an advance directive is to define the medical care desired and to specify whom to ask for decisions in the future, in order to make medical decisions that are consonant with the wishes and values of the person who has become incapacitated.

Advance Directives

Formal written advance directives may take the form of a living will, a durable power of attorney for healthcare (DPOAHC), or some combination of the two. The terminology, statutes and documents relating to advance directives vary from state to state. Nevertheless, an advance directive created in one state is valid in all other states, and advance directives are thus portable from state to state. By law, healthcare facilities may not base admission on whether a person has or does not have an advance directive. (482 CRF section 489.102(a)(3)) In any healthcare facility, a copy of written advance directives should be placed in the patient's chart so that all caregivers are aware of its existence and contents.

Living Wills and Powers of Attorney

A living will is a document in which a person specifies preferences for care or treatment in the event of future incapacity. A separate document designating a surrogate is called a durable power of attorney for healthcare. Some states may require that a DPOAHC be separate from the living will; others may combine the provisions of a living will and a DPOAHC. A person completing a living will or DPOAHC may rescind or change it at any time, provided he or she still possesses the capacity to make decisions. Neither a living will nor a DPOAHC becomes active unless the person becomes incapacitated. In some states, an individual may choose to activate a surrogate while he or she still has decision-making capacity.

Living wills may vary considerably in their degree of detail. They may simply specify general goals, such as comfort over aggressive treatment or discontinuation of treatment that appears to be futile. They may also specify types of care or treatment, such as attempted cardiopulmonary resuscitation, intubation, intravenous hydration or medication, hospitalization in the event of a serious illness, antibiotic therapy, or the use of feeding tubes.

A person completing an advance directive cannot foresee or address all the situations in which choices about treatment may be required. Choosing someone to make decisions on one's behalf provides additional flexibility in dealing with unforeseen circumstances.

For more information, visit amda.com/governance/whitepapers/surrogate/advance_directives.cfm.

IMAGING—A QUESTION OF OVERUSE?

Use of diagnostic imaging technology has increased dramatically, adding significantly to the nation's healthcare bill. The number of CT and MRI units has more than doubled over the past decade, and that has led to a doubling and tripling of CT and MRI scans respectively, reports Health Affairs. The rise in medical imaging adds more than $1.2 million annually to Medicare costs alone.

Is the increased use justified by improved health outcomes? What about the radiation risks to patients? Would other conventional, less expensive diagnostic tests work as well? The use versus overuse debate won't be resolved without more evidence of the cost-effectiveness of imaging tests and the effect on patient care.

An Unhealthy Economy Takes a Toll

Too many patients skimping on healthcare could lead to serious problems for everyone.

Is the current rocky financial situation having a destabilizing effect on your patients' health? A growing number of Americans have family budgets so tight they're now forced to scale back on medical care. Making tough choices in hard times is probably not an issue you've talked about with patients in the past, but addressing it now may help prevent more serious health problems for them down the road.

How widespread is the problem? A 2008 Commonwealth Fund survey found that half of Americans with chronic diseases said they skimped on care during the past two years for cost reasons. Among those surveyed, 43 percent said they hadn't refilled prescriptions, they'd split pills or they'd skipped doses to make the supply last longer. Thirty-six percent said they hadn't seen a doctor for a medical problem or incident. And 38 percent said they didn't get a recommended test, treatment or follow-up evaluation. Note that these findings reflect conditions before the collapse of the global financial markets.

What's alarming about the situation is the intermediate- and long-term consequences of a large number of people not getting care when it's needed. Short-term care cutbacks serve to light the fuse for a future explosion of serious medical conditions requiring costly hospitalizations.

What You Can Do to Help Your Patients

[1] Address the issue of financial stress as a health issue that's affecting everyone. Use the opportunity to remind patients why physical exercise, a good diet, adequate sleep and a social support network are better alternatives than couch-potato retreats, junk food, smoking and alcohol.

[2] Point out that some people are looking for ways to reduce medical expenses. Explain that some cost-cutting decisions can have serious medical consequences. State your willingness to help educate patients.

[3] Review the treatment plan with the patient, then ask about compliance in a non-judgmental way. For example: "Are there any things you've done differently with your medications?"

[4] Mention options, such as a medication switch to a lower-cost, generic version. Provide printed information about prescription-assistance programs and other sources of care that patients may need to tap during hard times.

Few people are comfortable discussing their finances, so tread with sensitivity and keep the focus on how to help the patient stay as healthy as possible.

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