

Referral and Coordination of Care

UPMC Health Plan relies on each provider to ensure the appropriate use of resources by delivering quality care in the proper setting at the right time. UPMC Health Plan’s approach to accountability is based on the belief that providers know what is best for their patients. Network providers are responsible for determining the type of care the UPMC Health Plan member needs and the appropriate provider or facility to administer that care.

We rely on our providers to:

- Provide the appropriate level of care
- Maintain high quality
- Use health care resources efficiently

Providers are encouraged to coordinate a member’s care with other specialists, therapists, hospitals, laboratories, and facilities in the UPMC Health Plan network appropriate to the member’s benefit plan.

UPMC Health Plan does not require a referral form, but providers must follow a coordination process to ensure high-quality care and accurate reimbursement for services.

The only time a provider should send a member to another provider (specialist, therapist, lab, or hospital, etc.) outside the UPMC Health Plan provider network is when extenuating circumstances require the use of an out-of-network provider or when the only available provider is not part of the UPMC Health Plan network.

To refer a member to an out-of-network provider, the referring provider must obtain prior authorization from Medical Management by calling 1-800-425-7800 or sending a fax to 412-454-2057. Failure to obtain prior authorization will result in denial of the claim. The referring provider must give the reason(s) for the out-of-network referral. If written information is required, send it to:

UPMC Health Plan
 Medical Management Department
 One Chatham Center
 112 Washington Place
 Pittsburgh, PA 15219

Low Back Pain Program

UPMC Health Plan has a policy that covers the Surgical Management of Low Back Pain when it is medically necessary and when it is covered under the member’s specific benefit plan.

To review the Surgical Management of Low Back Pain Policy (Policy Number MP.043), go to www.upmchealthplan.com/pdf/PandP/MP.043.pdf.

To obtain a copy of the Certificate of Medical Necessity (CMN-Surgical Management of Low Back Pain), visit our website at www.upmchealthplan.com/providers/medmgmt.html. The CMN is not required as part of the prior authorization process but is available for those providers who wish to download and submit it electronically or via fax.

Walgreens — Take Care Clinics Update

You probably already know that effective Jan. 1, 2012, Walgreens pharmacies no longer participate in the UPMC Health Plan pharmacy network.

Regarding the Take Care Clinics located inside of Walgreen’s, effective March 1, 2012, they will no longer participate in our network.

To find another convenience care (retail) clinic, please visit our website at www.upmchealthplan.com, click on “Find a Doctor,” and then select “Find an urgent care or convenience care clinic.”



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Provider Services:
1-866-918-1595
www.upmchealthplan.com/providers

ROUTE TO:

- Physicians
- Clinical Staff
- Office Manager
- Office Staff
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QUALITY CORNER

Counseling Older Adults Makes a Difference

Nicholas DeGregorio, MD, FACP, MMM

Osteoporosis, falls, and fractures are a common and deadly combination among older adults. Education, awareness, and prevention can improve both the length and quality of life for seniors. In this regard, the nature and extent of physician counseling can make a big difference.

Ten million Americans, mostly over the age of 50, have osteoporosis,¹ which results in about 1.5 million fragility fractures per year.² One in three Americans over age 65 fall each year;³ 1 in 2 fall by age 80.⁴ Of those who fall, 20%–30% suffer serious injuries resulting in \$19.2 billion in annual direct costs;³ 61% of those costs relate to fractures.⁵ Osteoporotic fractures are associated with poor outcomes, including substantially higher rates of mortality and morbidity from pain, limited mobility, decreased quality of life, disability, and inability to live independently.

Because osteoporosis is usually silent until a fracture occurs, it is generally out of sight and out of mind. Although seniors think about and fear falling, as well as frequently fall, unless asked, they will not usually discuss this with their doctor. In one survey, 36.2% of older adults reported having a fear of falling and 9.6% (3.5 million) reported falling within the previous 3 months.⁶ Seniors are 3–4 times more likely to fall if they have muscle weakness or problems with balance or gait.⁵

Undiagnosed vitamin D deficiency* is not uncommon and can contribute to osteoporosis, muscle weakness, and falls.⁷ Proximal muscle strength and speed of performance steadily improve as 25-hydroxyvitamin D levels increase from 4ng/ml up to 40ng/ml.⁸ A 5-month randomized controlled trial among nursing home residents receiving 800IU vitamin D₂ plus calcium daily, showed a 72% reduction in the risk for falling compared to the placebo group.⁹ Lower doses of supplemental vitamin D were less effective.

Most seniors are relatively inactive, yet regular physical activity is the single most effective intervention shown to reduce falling.⁴ In a 2003 RAND meta-analysis, regular physical activity that improved cardiovascular endurance, muscular strength, flexibility, and balance, reduced fall risk by 12% and the actual number of falls by 19% among seniors.⁴ Although 71.8% of seniors believe physical activity prevents falls, 78% do not engage in any regular form of exercise.¹⁰

In summary, many older patients are at risk for falls and fractures from silent osteoporosis and a gradual decrease in strength and balance.

Many seniors believe these changes are a normal part of aging and will not bring it to your attention. Below are ways to help your older patients:

- Assess, screen, and actively treat osteoporosis before they have a fracture.
- Ask if they have fallen or had near-falls in the past 12 months.
- Ask about and evaluate for reduced balance and loss of strength.
- Explore and manage contributors to falls and poor balance, including medication side effects, decreased vision, urinary incontinence, postural hypotension, or comorbid medical conditions.
- Emphasize the importance of regular exercise in improving strength, endurance, and balance; reducing the risk of falls and fractures; and increasing the ability to live independently.
- Help seniors choose forms of exercise they enjoy and can perform.
- Encourage and motivate your older patients to exercise regularly.
- Consider checking 25-hydroxyvitamin D levels and treat aggressively to achieve levels of 30ng/ml or greater.

*Vitamin D deficiency has been defined as < 20ng/ml, but based on normalization of PTH levels and intestinal calcium absorption; 21–29ng/ml may be considered relative insufficiency; and > 30ng/ml is most consistent with sufficient 25-OH vitamin D levels.⁷

References:

1. National Osteoporosis Foundation. "America's Bone Health: The State of Osteoporosis and Low Bone Mass in Our Nation." Washington D.C., 2002. www.nof.org/advocacy/prevalence/index.htm.
2. Raisz LG. "Screening for Osteoporosis." *The New England Journal of Medicine*, 2005 July 14;353(2):164-171.
3. CDC Online: "Costs of Falls Among Older Adults." Updated: August 28, 2008, <http://www.cdc.gov/ncipc/factsheets/fallcost.htm>.
4. Rand Corporation (Prepared for the U.S. Department of Health and Human Services). "Falls Prevention Intervention in the Medicare population." *Rand Health: Evidence Report and Evidence-Based Recommendations*, 2003.
5. Stevens JA et al. "The Costs of Fatal and Non-fatal Falls Among Older Adults." *Injury Prevention*, 2006;12:290-295.
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7. Hollick MF. "Vitamin D Deficiency." *The New England Journal of Medicine*, 2007 July 19;357:266-281
8. Bischoff-Ferrari HA et al. "Estimation of Optimal Serum Concentrations of 25-hydroxyvitamin D for Multiple Health Outcomes." *American Journal of Clinical Nutrition*, 2006;84:18-28 [Erratum, *Am J Clin Nutr* 2006;84:1253.]
9. Broe KE et al. "A Higher Dose of Vitamin D Reduces the Risk of Falls in Nursing Home Residents: A Randomized, Multiple-Dose Study." *Journal of the American Geriatric Society*, 2007;55:234-239.
10. Federal Interagency Forum on Aging Related Statistics. "Older Americans 2010: Key Indicators of Well-being." *Federal Interagency Forum on Aging-Related Statistics*. Washington, D.C.: U.S. Government Printing Office. July 2010. <http://www.agingstats.gov>.

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Is it 2013 yet?

The change from ICD-9 to ICD-10 is coming fast!

Are you ready for the change in coding and documentation coming in 2013? ICD-10-CM/PCS will become the official coding system used in the United States effective October 1, 2013. Providers and practices must consider the drastic changes in the codes and many other things as they prepare for the go-live date.

Why the change? ICD-10-CM/PCS will enhance the efficiency of clinical data collection and the quality of administrative data. The system incorporates greater specificity, includes updated medical terminology and disease classifications, provides the ability to compare mortality and morbidity data, and captures risk factors in primary care. The United States will now be on par with over 140 other countries that have been using the ICD-10 for years. Using this coding system will promote international agreement and comparability in classification, collection, processing, and presentation of health data.

How will the new diagnostic and procedures codes appear? Current diagnostic codes will expand from 3–5 characters to 3–7 characters. Inpatient procedural codes will expand from 3–4 characters to 7 characters. An example of each is shown below.

| Type of Code | ICD-9 | ICD-10 |
|-----------------|--|--|
| Diagnostic Code | 813.06 – Closed fracture of neck of radius | S52.131a – Displaced fracture of neck of right radius, initial encounter for closed fracture |
| Procedure Code | 42.89 – Repair esophagus | ODQ107Z – Repair, esophagus, upper, open without autograft |

What should providers do? The first step is to assess your practice's readiness for ICD-10-CM/PCS. Several agencies provide excellent tools for providers.

Two websites with a wealth of information about ICD-10 preparation, implementation, and follow-up are:

<http://www.cms.gov/ICD10>
<http://www.ahima/icd10>

UPMC Health Plan sent out a readiness assessment survey in December. Please remember to complete and return it to Network Management.

We will provide education on the changes to the coding system and the required documentation changes for our network providers.

If you did not respond to the initial survey, we will send a follow-up ICD-10 readiness assessment survey to your office this month.

Look for ongoing articles in the *Physician Partner Update* newsletter regarding the ABCs of ICD-10-CM/PCS.

Let's get ready for October 1, 2013!

UPMC Individual *Advantage* — Guaranteed Renewable Health Insurance for Individuals and Families

UPMC Health Plan is pleased to announce the release of UPMC Individual *Advantage* Guaranteed Renewable health insurance plans that will expand the product line from its current short-term-only health plans.

The plans are medically underwritten, and they will have a variety of monthly payments available. Deductible levels range from zero to \$5,000 dollars.

Available for individuals only or individuals and their dependents, the plans offer maternity and behavioral health coverage as well as preventive care at 100%. Routine maintenance medications are not subject to the deductible, and generic drug copayments are as low as \$4.

UPMC Individual *Advantage* includes Value Plans — EPO plan designs with a range of deductible options from \$500 to \$5000 with 80% coinsurance, as well as a zero-dollar deductible plan with 70% coinsurance. Members will have copayments for PCP and specialist visits prior to the deductible.

UPMC Individual *Advantage* also offers Savings Plans that can be paired with an HSA (Health Savings Account). Savings Plans are based on the EPO platform and offer tax-advantaged features. These plans offer deductibles of \$1300, \$2500, and \$5000.

Watch for further announcements.



UPMC HEALTH PLAN

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