UPMC HEALTH PLAN PHYSICIAN PARTNER Update

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## Treatment of Chronic Low Back Pain

Beginning January 1, 2012, UPMC Health Plan is implementing a comprehensive clinical initiative focusing on the treatment of chronic low back pain. Effective January 1, surgery for low back pain will require prior authorization to determine medical necessity.

Red flags and exclusionary diagnoses for addressing urgent surgical management of acute back pain are identified in the Surgical Management of Low Back Pain Policy. The policy is available for review in the online Policy and Procedures Manual located on our website at www.upmchealthplan.com.

To be considered for surgery, patients with chronic low back pain must have:

- Tried and failed a 3-month course of conservative management, which includes physical therapy, chiropractic therapy, and medication.
- Completed UPMC Health Plan's Low Back Pain Health Coaching Program.

The program includes a Web-based shared decision-making tool to help members understand the pros and cons of surgery and high-tech radiology. Care managers can assist members in obtaining appropriate care. Your patients can call 1-866-778-6073 to enroll.

Appropriate use of high-tech radiology will be monitored for low back pain diagnosis.

We feel strongly that this clinical initiative will improve the quality of care for members considering low back surgery and will facilitate their involvement in the decision-making process. Surgical procedures for low back surgery performed without authorization will not be reimbursed at either the specialist or hospital level.

The prior authorization process is:

- Fax clinical information, including a chronology of the conservative measures employed prior to the decision to perform surgery, to the Clinical Operations Department at 412-454-2057.
- Review decisions will be communicated to the requesting provider.
- If you have questions, call Clinical Operations at 1-800-425-7800.

This policy was developed using evidence-based literature and professional society guidelines, as well as the input of external medical professionals with expertise in the area.

## Beating the Blues*US*

At least one study on the prevalence of depression in primary care settings has stated that between 10% and 15% of all patients have diagnostically significant depression or anxiety and that nearly 10% of office visits are depression related. Patients with depression often have more physical symptoms and anxiety can contribute to a patient's difficulty with following treatment plans. For patients with chronic physical disease, incidence of depression is much higher, between 50% and 60%. And for people with a new diagnosis of a serious illness, anxiety occurs at a rate higher than 90%.

An evidence-based treatment for mild-to-moderate depression and anxiety is something called cognitive behavioral therapy or CBT. CBT is a well-studied treatment that helps patients understand the relationship between their thoughts, actions, and feelings. The treatment gives patients the skills that they need to change their thoughts and actions and thereby improve their feelings. CBT has been found to be more effective than medication for people with mild-to-moderate depression.

If you are a PCP who is having difficulty obtaining CBT referrals for your patients, UPMC Health Plan can offer you a solution. UPMC Health Plan has partnered with a company in the United Kingdom to develop an American version of a well-supported computer-delivered CBT program. This program, widely in use in Europe, is now available free of charge to UPMC Health Plan members. The treatment program, called Beating the Blues*US*, has complete fidelity to face-to-face CBT and, in fact, has shown itself to be even more effective than face-to-face treatment for some users.

More information about how to make referrals for Beating the Blues*US* for your patients will be coming soon. Please check our website or call Provider Services at 1-866-918-1595.

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**Provider Services: 1-866-918-1595**

**www.upmchealthplan.com/providers**

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## QUALITY CORNER

**Improving Clinical Outcomes by Increasing Medication Adherence**

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BREAKING NEWS: Medicines don't work if you don't take them. Poor compliance with medications is prevalent and significantly affects the management of patients with chronic conditions and contributes to hospital readmissions and poor clinical outcomes. Only 50% of patients suffering from chronic diseases maintain good adherence;[1] it's even lower if a patient is on multiple medications.[2] Not surprisingly, increased medication adherence is associated with improved clinical outcomes[3,4] and reduced health care costs.[5] Improvement in medication adherence can be influenced by provider engagement and the education of members regarding self-support, especially when performed soon after a medication is prescribed.[6] With concerted physician-patient collaboration, increased medication adherence has been found to be an achievable self-management goal.[7]

Commonly used medication adherence metrics are the Medication Possession Ratio (MPR) and the Proportion of Days Covered (PDC), as defined in Table I. Good medication adherence is defined as an MPR ≥ 0.8 or a PDC with ≥ 80% of the days covered for the measurement period.

Table I – Definitions of Medication Adherence Metrics[8]

| Metric | Notes |
|---|---|
| MPR = Sum of days' supply for all fills in a time period / Number of days in period | • Denominator defined as interval between first and last fills or interval between first fill and fixed date<br>• Prone to inflation due to overlapping fills from drug switches or dual drug therapy in same drug class<br>• Simple to calculate |
| PDC = Number of days covered by med in a time period / Number of days in period | • Looks at each day in period to determine if drug on hand<br>• More conservative estimate when switching drugs or using dual drug therapy in same class<br>• More complex to calculate |

Recognizing the importance, CMS has added and heavily weighted new medication adherence measures in the 2012 STARS rating measurement set. See Table II for a description of the 3 adherence metrics, plus a new measurement for the use of appropriate medications for the management of hypertension with comorbid diabetes.

Table II – New 2012 CMS Stars Medication Metrics*

| Category | Metric |
|---|---|
| Medication Adherence | *Medication Adherence for Oral Diabetes Medications* — Percent of members > 18 years old prescribed medication for type 2 diabetes, with PDC > 80% for the biguanide, sulfonylurea, thiazolidinedione, or DPP-IV drug classes |
| | *ACEI or ARB Adherence for Hypertension* — Percent of members > 18 years old prescribed an ACEI or ARB medication for HBP, with PDC > 80% |
| | *Medication Adherence for Cholesterol (Statins)* — Percent of members > 18 years old prescribed a statin for high cholesterol, with PDC > 80% |
| Appropriate Management of HBP + DM | *Diabetes Treatment* — Percent of members with DM prescribed medication for HBP who receive an ACEI** or an ARB*** medication |

*CMS denominator includes Part D (pharmacy) members of Medicare and Special Needs Plans.
**Angiotensin-Converting Enzyme Inhibitor
***Angiotensin Receptor Blocker

References:


1. Cheever LW. In Anderson JR, ed. *A Guide to the Clinical Care of Women with HIV*, 2005 Edition. Washington, DC. U.S. Dept. of Health and Human Services, 2005.
2. Nathan DM et al. *Diabetes Care*, 2006;29(8):1963-1972.
3. Gehi AK et al. *Arch Int Med*, 2007;167(16):1798-1803.
4. Rhee MK et al. *Diabetes Educator*, 2005;31(2):240-250.
5. Shenolikar RA et al. *Clinical Therapeutics*, 2006;28(8):1199-1207.
6. Casebeer L et al. *BMC Fam Pract*, 2009;10:48.
7. Vijan S et al. *Journal of General Internal Medicine*, 2005;20(5):479-482.
8. Nau, D. Senior Director, Research and Performance Improvement. Presentation: "Adherence Measurement," *Pharmacy Quality Alliance (PQA)*, May 31, 2011.






## Medicare Marketing Guidelines

The Medicare Marketing Guidelines reflect the Centers for Medicare & Medicaid Service's (CMS) current interpretation of the marketing requirements and related provisions of the Medicare Advantage (MA) and Medicare Prescription Drug Plan (PDP) rules and 1876 cost contracts (Chapter 42 of the Code of Federal Regulations, Parts 417, 422, and 423).

Medicare marketing guidelines are scrutinized and reinforced by CMS, and strict adherence to CMS Medicare marketing rules is critical. In a climate where Medicare products are competing for market share, high-pressure Medicare sales may lead some organizations to inadvertently engage in inappropriate marketing and sales activities. The Medicare Marketing Guidelines are designed to guide plans and providers in assisting beneficiaries with plan selection, while at the same time striking a balance to ensure that provider assistance results in plan selection that is always in the best interest of the beneficiary. To assist plans and providers in determining which actions are appropriate for the provider setting, CMS has provided the following guidance.

**It would be inappropriate for providers to be involved in any of the following actions:**

- Offering sales/appointment forms.
- Accepting enrollment applications for MA/MA-PD plans or PDPs.
- Making phone calls or directing, urging, or attempting to persuade beneficiaries to enroll in a specific plan based on the financial or other interests of the provider.
- Mailing marketing materials on behalf of plan sponsors.
- Offering anything of value to induce plan enrollees to select them as their provider.
- Offering inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Health screening is a prohibited marketing activity.
- Accepting compensation directly or indirectly from the plan for beneficiary enrollment activities.
- Distributing materials/applications within an exam room setting.

**Providers contracted with plan sponsors (and their contractors) are permitted to do the following:**

- Provide the names of plan sponsors with which they contract and/or participate.
- Provide information and assistance in applying for the Laboratory Information System.
- Make available and/or distribute plan marketing materials, including provider affiliation materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials from all plans with which they participate. CMS does not expect providers to proactively contact all participating plans to solicit the distribution of their marketing materials; rather, if a provider agrees to make available and/or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept future requests from other plan sponsors with which it participates. To that end, providers are permitted to:
    - Provide objective information on plan sponsors' specific plan formularies, based on a particular patient's medications and health care needs.
    - Provide objective information regarding plan sponsors' plans, including information such as covered benefits, cost sharing, and utilization management tools.
    - Make available and/or distribute PDP enrollment applications, but not MA or MA-PD enrollment applications, for all plans with which the provider participates.
- Refer their patients to other sources of information, such as SHIPs, plan marketing representatives, their State Medicaid Office, local Social Security Office, and CMS (website at http://www.medicare.gov/ or 1-800-MEDICARE).
- Print out and share information with patients from the CMS website.

Questions regarding these guidelines or UPMC Health Plan Medicare products should be directed to your Network Manager.

UPMC Health Plan

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