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Reinstating the Specialty Referral Requirement


From Paul Mendis, MD, Chief Medical Officer of Neighborhood Health Plan



Paul Mendis was recently selected as Massachusetts Health Council President, and was also named a "Champion in Health Care" by the Boston Business Journal. A senior health care executive with over 25 years of experience in Medicaid, Medicare and commercial managed care, Dr. Mendis has experience working with community health centers and vulnerable populations, strengthening his role on various boards, including the Aligning Forces for Quality Steering Committee, the Massachusetts Health Disparities Council, and the Massachusetts Medicaid Policy Institute.

In 2007, Neighborhood Health Plan eliminated its longstanding specialty referral requirement. Patients were encouraged to discuss such referrals with their primary care clinician (PCC) but the PCC was no longer required to submit paperwork to NHP to ensure specialist payment. At the time, few of our practices were actively using the referral requirement to direct care. The health plan subsequently allowed its members to access any contracted specialist and maintained a prior authorization process only for non-contracted specialists. This administrative simplification measure was generally well-received by members. In addition, NHP and its affiliated practices were then able to redeploy support staff to more value added activities.

As we all know, the health care environment has undergone a substantial shift in the last four-and-a-half years. With the economic downturn, controlling costs while maintaining or improving quality is imperative. Key stakeholders such as government purchasers, employers, and our members are expecting us to be more efficient and effective. Payment reform models are being introduced to better align incentives between providers and payers. NHP expects to have more such arrangements in place during 2012.


In order to better position us to respond to these pressures, NHP will be reinstating the specialty referral requirement* as of January 1, 2012. This will be an important tool we can use jointly with our primary care groups to direct care to those specialists and hospitals demonstrating high quality at a reasonable cost. Electronic web-based submission via NHPNet will be available to minimize the administrative burden. Accessing the least efficient providers of specialty and hospital services will require prior authorization as of that date. More details will be forthcoming in separate communications over the next few weeks. 

*Certain specialty services (OB/GYN, family planning, behavioral health and emergency medicine) are exempt from this referral requirement.



nhp.org

New Phone Number for Providers

Effective December 1, 2011, the number to reach NHP's service representatives is **1-855-444-4NHP (4647)** and our hours of operation are Monday through Friday, 8:30 a.m. to 5:00 p.m. *A reminder:* On Thursdays, our call center closes briefly between 3:00 p.m. and 4:00 p.m. for training purposes. As always, providers have instant access to claims status and other information around the clock with our provider portal, NHPNet. 

Evidence Shows Postpartum Visits Yield Great Benefits

By Matthew Collins, MD, Medical Director, Neighborhood Health Plan

Obstetrical and primary care organizations recognize the importance of postpartum care and in the coming months, providers will be implementing the Department of Public Health mandate to perform screening for postpartum depression. Yet, the average postpartum visit rate from members of NCQA-accredited commercial and Medicaid populations of health plans in 2009 was 83.6 percent and 64 percent respectively.

A systematic review published in the journal *Birth* found evidence to support the benefits of postpartum care among women selected for high risk. Specifically, women identified as high risk due to social situations, risk for depression, or teen age, benefited from postpartum visit

interventions. Such interventions ranged from intensive parenting education and depression screening to family planning advice. The results were better parenting skills, lower rates of depression, and lower rates of repeat unplanned pregnancy.

So, what are the barriers to postpartum care? A paper published this July in the *Maternal and Child Health Journal* used PRAMS data from Rhode Island to study the issue of prenatal and postpartum visit rates among Medicaid recipients. Study subjects from this research indentified the following barriers to prenatal and postpartum care:

- Not enough money
- No insurance card
- No transportation

- Difficulty scheduling appointments
- Inaccessible appointment times.

Practices may consider helping to reduce these barriers by offering accessible appointment times and/or making it easier for patients to scheduled visits.

NHP care managers have been actively seeking to lower such barriers when identified. Providers should make referrals to NHP any member identified as needing help reducing barrier to getting or keeping prenatal and postpartum appointments.

Shaw, E., et. al, Systematic Review of the literature on Postpartum Care: Effectiveness of Postpartum Support to Improve Maternal Parenting, Mental Health, Quality of Life, and Physical Health. *Birth* 33:3, September 2006.

Bromley, E., et. al, Disparities in Pregnancy Healthcare Utilization Between Hispanic and Non-Hispanic White Women in Rhode Island, *Maternal and Child Health Journal*, published online July 17, 2011.



Cervical Screening Guidelines Ignored

(Excerpt) By Kristina Fiore, Staff Writer, *MedPage Today*, Published: August 18, 2011. Reviewed by Robert Jasmer, MD, Associate Clinical Professor of Medicine, University of California, San Francisco and Dorothy Caputo, MA, RN, BC-ADM, CDE, Nurse Planner

Many physicians recommend the HPV and Papanicolaou co-tests for cervical cancer screening on an annual basis, despite guidelines that call for re-screening every three years, researchers said.

National survey data show that about 51 percent of providers ordered the co-test, but in clinical vignettes, only about 14 percent recommended re-screening in three years for women with normal results, Katherine Roland, MPH, of the Centers for Disease Control and Prevention in Atlanta, and colleagues reported online in the *American Journal of Obstetrics & Gynecology*.

"Annual cervical cancer screening continues to be a common recommendation, regardless of whether a screening history has been established or an HPV test has been ordered," the researchers wrote.

Guidelines from the American Cancer Society in 2002 and the American College of Obstetricians and Gynecologists in 2003 recommend the co-test for women age 30 and up. If the results are normal on both tests, a three-year interval is recommended until the next screening.

To assess adoption of the guidelines, the researchers looked at 2006 data from two CDC surveys: the National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey, which included responses from 376 private office-based physicians and 216 physicians from hospital outpatient facilities.

Among office-based providers, 51 percent reported ordering the HPV co-test, as did a similar proportion of hospital based practices (51.4 percent). In both cases, the majority of tests were ordered appropriately, for women over age 30 (64.1 percent and 62.4 percent, respectively).

When doctors were given three clinical vignettes involving women ages 30 to 60, most of those who ordered the HPV test said they would order the next Pap test within a year:

- For those with a current normal Pap test, no HPV test, and two consecutive normal Pap tests, 76.4 percent of office-based and 85.2 percent of hospital-based doctors said they'd recommend a new screen in 12 months.
- For those with a normal Pap, a negative HPV, and two consecutive normal Pap results, 66.6 percent of office-based and 72.7 percent of hospital-based doctors recommended re-testing in a year. But the researchers noted that only 14 percent of office-based doctors would recommend the next test three years, as guidelines recommend, the researchers said.
- For those with a normal Pap and a negative HPV test, but no documented Pap test results over the previous five years, 73.4 percent of office-based and 73.5 percent of hospital-based physicians recommended another screen in a year. In both cases, about about a quarter recommended re-testing before a full year passed.

Roland and colleagues noted that the recommendations among the physicians to extend the screening interval to three years were most likely to occur if a woman had a normal HPV test and a history of normal Pap results.

The researchers reported no conflicts of interest. Primary source: *American Journal of Obstetrics & Gynecology*. Source reference: Roland KB, et al "Human papillomavirus and Papanicolaou tests screening interval recommendations in the United States" *Am J Obstet Gynecol* 2011; DOI: 10.1016/j.ajog.2011.06.001.

Full article at: www.medpagetoday.com/OBGYN/GeneralOBGYN/28098



Pharmacy and Therapeutics Update

The Pharmacy and Therapeutics (PT) Committee has reviewed the following medications.

Tier 1 (New Generics)	Tier 2	Tier 3	
Activella (estradiol & norethindrone acetate)	Edurant (rilpivirine)	Atelvia (risedronate)	Latuda (lurasidone)
Arixtra (fondaparinux)		Butrans (buprenorphine patch)	Nexiclon (clonidine extended release)
Carbatrol (carbamazepine)		Carbaglu (carglumic acid)	Victrelis (boceprevir)
Levaquin (levofloxacin)		Cycloset (bromocriptine)	Xalkori (crizotinib)
Methergine (methylergonovine)		Incivek (telaprevir)	
		Lastacaft (alcaftadine)	

The PT Committee has voted to implement a quantity limitⁱ on:

- Atelvia (risedronate): 4 tablets/28 days
- Butrans (buprenorphine patch): 4 patches/28 days
- Cycloset (bromocriptine): 180 tablets/30 days
- Lastacaft (alcaftadine): 3 mL/30 days
- Latuda (lurasidone): 30 tablets/30 days
- Nexiclon (clonidine extended release): 90 tablets/30 days or 236ml/ 30 days

The PT Committee has voted to add Butrans to the Long-Acting Narcotic Step Therapy Programⁱⁱ effective August 2011.

1 st Line Medications	2 nd Line Medications	3 rd Line Medications
morphine ER	fentanyl patch	Butrans (buprenorphine) patch
methadone	OxyContin (oxycodone ER)	Exalgo (hydromorphone ER)
	Avinza (morphine sulfate ER)	
	Kadian (morphine sulfate ER)	

The PT Committee has voted to add Latuda to the Atypical Antipsychotics Step Therapy Programⁱⁱ effective August 2011.

1 st Line Medications	2 nd Line Medications	3 rd Line Medications
risperidone	Abilify (aripiprazole)	Saphris (asenapine) sublingual tablets
	clozapine	Fanapt (iloperidone) tablets
	Geodon (ziprasidone)	Latuda (lurasidone) tablets
	Invega (paliperidone)	
	Seroquel (quetiapine)	
	Zyprexa (olanzapine)	

The PT Committee has voted to add Lastacaft to the Ophthalmic Anti Allergy Step Therapy Programⁱⁱ effective October 24, 2011.

1 st Line Medications	2 nd Line Medications	3 rd Line Medications
Alaway OTC (ketotifen 0.025%)	azelastine 0.05% (Optivar)	Bepreve (bepotastine 1.5%)
Claritin (ketotifen 0.025%) solution		Elestat (epinastine 0.05%)
Zaditor OTC (ketotifen 0.025%)		Emadine (emedastine 0.05%)
ketotifen OTC (0.025%)		Lastacaft (alcaftadine 0.25%)
		Patanol (olopatadine 0.1%)
		Pataday (olopatadine 0.2%)

The P&T Committee has voted to add Atelvia to the Bisphosphonate Step Therapy Programⁱⁱ effective October 24, 2011.

1 st Line Medications	2 nd Line Medications	3 rd Line Medications
generic alendronate tablets	Boniva (ibandronate) tablets	Atelvia (risedronate) tablets
Actonel (risedronate) tablets	Fosamax (alendronate) solution	
	Skelid (tiludronate) tablets	

Continued on page 4

Pradaxa and Brillanta Now Approved for Use

Aradaxa and Brillanta have been recently approved by the Food and Drug Administration (FDA); Coumadin and Plavix are current therapy alternatives.

Brand Name	Generic Name	FDA Indication	Adverse Effects	Dosing	Average Wholesale Price
Coumadin	warfarin	<ul style="list-style-type: none"> • Recurrent myocardial infarction (MI)/thromboembolic event: • Thromboembolic complications • Venous thrombosis/pulmonary embolism 	Most frequent adverse reactions were bleeding and gastrointestinal events.	<ul style="list-style-type: none"> • Initial dosage: 2 to 5 mg daily. • Maintenance dosage: 2 to 10 mg daily. 	Average cost per prescription: \$11.68
Pradaxa	dabigatran etexilate mesylate	To reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation	Most frequent adverse reactions leading to discontinuation of Pradaxa were bleeding and gastrointestinal events (i.e., dyspepsia, nausea, upper abdominal pain, gastrointestinal hemorrhage, and diarrhea)	150 mg taken orally, twice daily, with or without food. For patients with CrCl 15-30 mL/min, the recommended dose is 75 mg twice daily. Instruct patients to swallow the capsules whole.	<ul style="list-style-type: none"> • \$4.37 per dose • Average cost per prescription: \$223.34
Plavix (Will be available as a generic in May, 2012)	clopidogrel	<ul style="list-style-type: none"> • Acute coronary syndrome (ACS) <ul style="list-style-type: none"> - Non-ST-segment elevation ACS [unstable angina (UA)/non-ST-elevation myocardial infarction (NSTEMI)] - For patients with ST-elevation myocardial infarction (STEMI) • Recent myocardial infarction (MI), recent stroke, or established peripheral arterial disease 	<ul style="list-style-type: none"> • Bleeding • Thrombotic thrombocytopenic purpura 	<ul style="list-style-type: none"> • Acute coronary syndrome <ul style="list-style-type: none"> - Non-ST-segment elevation ACS (UA/NSTEMI): 300 mg loading dose followed by 75 mg once daily, in combination with aspirin (75–325 mg once daily) - STEMI: 75 mg once daily, in combination with aspirin (75–325 mg once daily), with or without a loading dose and with or without thrombolytics • Recent MI, recent stroke, or established peripheral arterial disease: 75 mg once daily 	\$7.30/75mg
Brilanta	ticagrelor	<ul style="list-style-type: none"> • Acute coronary syndrome (ACS) • Non-ST-segment elevation ACS [unstable angina (UA)/non-ST-elevation myocardial infarction (NSTEMI)] • For patients with ST-elevation myocardial infarction (STEMI) 	<ul style="list-style-type: none"> • Bleeding • Dyspnea • Headache 	<ul style="list-style-type: none"> • Loading dose: 180mg • Maintenance dose: 90mg bid with < 100mg aspirin daily 	\$4.35/90mg (\$8.70/day)




Pharmacy and Therapeutics Update

Continued from page 3

The PT Committee has voted to place a Prior Authorizationⁱⁱⁱ on the following medications:

- Carbaglu
- Cycloset
- Incivek
- Nexiclon
- Victrelis

Check www.nhp.org (Provider page) for the most up-to-date information about the NHP Pharmacy programs and the current medical necessity criteria. 

ⁱQuantity limits promote cost effective prescribing by limiting the number of units of medication that can be dispensed over a given time. These are established based on strengths available and the recommended doses.

ⁱⁱStep Therapy is an automated case review based on P&T established guidelines and the individual member's NHP pharmacy profile. This process occurs with a pharmacy claims submission and does not require provider intervention if prior NHP pharmacy claims indicate use of the first line and/or second line medications.


ⁱⁱⁱPrior Authorization is an individual case review compared to P&T established guidelines before a prescription for the specific medication will be covered.

Practice Guidelines

NHP endorses the *Massachusetts Health Quality Partners Adult and Pediatric Preventive Care Guidelines* and the *Prenatal Care Guidelines*, the *National Heart, Lung, Blood Institute Guidelines for the Diagnosis and Management of Asthma*, and the *Massachusetts Asthma Action Plan*, the *Institute for Clinical Systems Improvement Guideline on the Treatment of Major Depression in Adults in Primary Care*, the *Massachusetts Guidelines for Adult Diabetes Care*, the *U.S. Department of Health and Human Services HIV/AIDS Treatment Information Service Guidelines*.

Through Beacon Health Strategies, NHP's behavioral health partner, NHP endorses the American Academy of Child and Adolescent Psychiatry's (AACAP) *Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder*.

To access these guidelines endorsed by NHP, at www.nhp.org, click on "Providers," go to "Clinical Resources," and then go to "Clinical Practice Guidelines."

Paper copies of all guidelines are also available upon request. Contact Catherine Jason, Director of Clinical Compliance and Education at 617-204-1427 or 1-800-433-5556, ext. 1427. 

Psychotropic Drug Intervention Program


For several years now, NHP's behavioral health partner, Beacon Health Strategies, has managed a Psychotropic Drug Intervention Program (PDIP) targeting NHP members who have psychotropic medication-related issues. Utilizing pharmacy claims data and evidence-based medicine algorithms, PDIP allows NHP to:

- Monitor medication adherence for members taking psychotropic medications which require consistent, ongoing use.
- Identify sub-therapeutic dosing of psychotropic medications which require therapeutic dosing.
- Identify poly-pharmacy of psychotropic medications.
- Recognize potential cases of uncoordinated care and prescribing by multiple clinicians treating the same member.
- Check for possible fraudulent or abusive prescriptive patterns.
- Monitor for outlier member cases where there are potential medication utilization safety concerns.

Essentially, PDIP seeks to improve the quality and safety of NHP members' psychotropic medication use. The program communicates with members about their


psychotropic medicines and why it's important to keep taking them until they and their prescribers mutually decide it is appropriate to stop. For example, if PDIP algorithms identify that a member has not filled or refilled a prescription when expected, the member may get a personal call, automated phone message, or a letter reminding him/her to keep taking the medicine. If PDIP algorithms indicate that a member is receiving psychotropic medication from more than one prescribing clinician, especially when within the same therapeutic class, both the member and involved prescribers will be notified of the need to coordinate care. NHP prescribers are typically notified of these situations via fax or mail.







Through PDIP, Beacon provides both medical and behavioral health clinicians access to timely and relevant information on psychotropic medications to support improved behavioral health outcomes for NHP members. In addition, by calling 1-877-591-2978, NHP prescribers can obtain psychotropic medication decision support from board-certified Beacon psychiatrists with psychopharmacologic expertise.

For more information about Beacon's PDIP program for NHP members, please call Beacon at 1-877-2978. 

Online Tool Helps Patients to Easily Check Drug Interactions

NHP's website offers a variety of tools to help providers and members make better-informed decisions about health care. One of them is the Drug Interaction Checker, which helps to find which drugs (or foods) may interact with their prescriptions. Simple icons are used to denote different levels of caution needed, from "possible drug-drug interaction" or "unknown" to "severe/more significant."

At the NHP website at www.nhp.org, simply click on "Healthwise Knowledgebase," then choose "Drug Interaction Checker." From there, just type in a drug name and follow instructions provided. 

	Possible food-drug interaction
	Possible drug-drug interaction
	"Severe/Most significant" warning
	"Serious/More significant" warning
	"Moderate/Significant" warning
	"Unknown," call doctor or pharmacist



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PCP Referral Never Needed for Outpatient Behavioral Health Services

NHP's behavioral health partner, Beacon Health Strategies (Beacon) appreciates that, as a primary care provider (PCP), you are likely to provide early assessment, education, and initial treatment for behavioral health (BH) issues your patients may experience. However, when a BH specialist is needed, Beacon's BH network has licensed and credentialed specialists with a wide spectrum of expertise available to address the full array of mental health, addictions, and behavioral conditions.

For your patients managed by Beacon for their BH care, a PCP referral is never required to meet with a qualified, in-network, BH provider. Once you have identified the need for specialty

BH care and discussed with your patient the importance of treatment, your patient can call the 800 number on the back of his/her insurance card to contact Beacon directly, 24/7, to obtain a list of qualified providers in their area. Patients can also access our extensive provider network by clicking on the "Locate a Provider" link on Beacon's website at www.beaconhealthstrategies.com.

If you have any questions or need assistance, please contact:

24-hour clinical access: 1-800-414-2820

Provider Relations: provider.relations@beaconhs.com
781-994-7556



New Phone Number for Providers: See Page 1