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Ongoing 2010 Medicare QIP Programs

CMS (Center for Medicare and Medicaid Services) requires managed care plans to implement a quality project each year. Since 2006, HealthAmerica Advantra has chosen to implement 4 different QIP's (Quality Improvement Programs), all program are ongoing for at least 4 years. HealthAmerica Advantra's uses activities and initiatives by various departments such as the Diabetes disease management team to impact these population outcomes for the preventative services listed below. Please review the four programs below and the targeted outcomes for each of them.

Osteoporosis (2006 Project)

- All Medicare female members age 67 years and older who had a fracture and who has a bone mineral density test or a prescription for an osteoporosis medication. The prescription for the osteoporosis medication or BMD must be within 6 months of the fracture. (HEDIS MEASURE – collected yearly)**
- All Medicare female members age 65 and older who had a bone mineral density test in the past two years.

Osteoporosis screening **	HEDIS 2004	HEDIS 2005	HEDIS 2006	HEDIS 2007	HEDIS 2008	HEDIS 2009	HEDIS 2010
HMO	21.85%	18.97%	25.48%	20%	31.2%	33.29%	35.07%
PPO	-----	-----	-----	N/R*	35.7%	35%	40.58%
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*not enough membership to qualify							
Osteoporosis (q 2 years scrn)	1/1/2004-12/31/05		1/1/06-12/31/07		1/1/08-12/31/09		

HMO	22.50	30.47%	25.60
PPO	N/R*	2.27%	24.27%

Chronic Obstructive Pulmonary Disease (COPD) - (2007 Project)

- HEDIS measure- All Medicare members age 42 years and older with a principle or secondary diagnosis of COPD (new or chronic) who had appropriate spirometry testing completed. *(Spirometry testing must be completed 2 years prior to the diagnosis and up to 6 months after the diagnosis for the member to be compliant for the HEDIS measure.)*
- All Medicare members diagnosed with COPD to receive an annual flu vaccine

COPD Spirometry testing **	HEDIS 2007	HEDIS 2008	HEDIS 2009*	HEDIS 2010
HMO	27.2%	36.1%	34.98%	50.32%
PPO	20%	33%	40%	66.60%

* Auditor specification change. Although comparable there was a change in how the measure was calculated.

** HEDIS measure collected yearly

COPD members who get annual flu shots	2007 season (9/06-3/07)	2008 season (9/07-3/08)	2009 Season (9/08-3/09)
HMO	55.43%	60.26%	58.17%
PPO	20%	50%	40%

Diabetes: (2008 project)

- HEDIS measure- All Medicare members age 18- 75 years of age with a principle or secondary diagnosis of Type I or II Diabetes (new or chronic) who had appropriate Diabetic dilated retinal eye exam during the year.
- All Medicare members diagnosed with Diabetes to receive an annual flu vaccine.

Eye Exam in Diabetics**	HEDIS 2008 (2007 rate)	HEDIS 2009 (2008 rate)	HEDIS 2010 (2009 rate)
Medicare HMO	79.25%	84.20%	82.56%
Medicare PPO	56.59%	64.19%	64.38%

**HEDIS measure collected yearly

Diabetic members who get annual flu shots	2008 season (9/07-3/08)	2009 season (9/08-3/09)
Medicare HMO	62.40%	61.52%
Medicare PPO	63.67%	64.20%

Glaucoma Screening: (2009 Project)

- HEDIS measure- All Medicare members age 65 years of age and older who had one or more eye exams for glaucoma by an eye care professional (Optometrist, Ophthalmologist) during the measurement year or the year prior.

Glaucoma**	HEDIS 2009	HEDIS 2010
Medicare HMO	69.13%	71.35%
Medicare PPO	64.33%	73.84%

** HEDIS measure collected yearly

We appreciate you assisting us with maintaining this project and complying with CMS. If you have any comments or questions on this program, please contact Janae Smith, RN at (412) 553-7355.

The HealthAmerica® NurseLine for Our Members*

The following information was shared with HealthAmerica's commercial members.

For helpful, 24-hour health care advice. HealthAmerica's NurseLine: 1.866.491.4462.

Call HealthAmerica's NurseLine toll-free, **24 hours a day, seven days a week including holidays**. A registered nurse will help you any time you are sick, injured or have any health care questions. You will get immediate answers and help in making the best health care decisions for you.

Our Nurses Can Help You With:

- Cuts, minor scrapes, burns and bruises.
- Colds, viruses, coughs and flu.
- Dizziness, headaches or sore throats.
- Back pain.
- General illness and physical discomfort.

When You Call, a Nurse Will:

- Ask you about your symptoms.
- Help you decide if you need to see a doctor or go to the emergency room.
- Offer advice on caring for yourself.

You Can Also Ask Our Nurses About:

- General health information questions.
- Questions about your medicines.
- The benefits and risks of specific medical procedures or tests.
- Tips to help you develop a healthier lifestyle.
- Making better decisions about your health care using our online tools.

Easy Access to Answers

Talk with registered nurses 24 hours a day, seven days a week by calling toll-free **1.866.491.4462**. Or, to receive an answer by e-mail, visit the NurseLine link at www.healthamerica.cvtv.com. Registered nurses will respond to your questions within 24 hours securely online via e-mail.

We Speak Your Language

Nurses can help you even if you don't speak English. The NurseLine offers translation services in more than 140 languages.

* NurseLine services are available to commercial members only.

Precertification of Spinal Fusion Procedures

What We Require

In order to ensure a smooth process for prior authorization of all elective spinal fusion procedures, please read through the criteria for our medical necessity review. The process includes review of the patient's clinical history and the safety and efficacy of implanted devices in accordance with the FDA approval of the device.

The following clarifies the information required to review the procedure and should help eliminate our need to contact your office for additional information:

- Diagnosis: acute traumatic injury with instability, non-traumatic instability, degenerative disc disease, spondylolisthesis, spinal stenosis, or bone tumor, etc.).
- Documentation of other conservative treatment.
- The official MRI report from the radiologist, not just the summary.
- Level(s) of fusion: cervical, thoracic or lumbar.
- Indication whether vertebrae is fractured.
- Documentation of any planned allograft, autograft, or both.
 - 1) Type of allograft
 - 2) Type of autograft
- If allograft:
 - 1) Use of a cage or implant w/ BMP.
 - 2) Form of BMP to be used.
- Surgical approach (i.e., anterior, posterior, endoscopic, or other).
- Use of any type of biomechanical implant not mentioned above.
- Name of manufacturer of any cage or implant to be used.

If you have any questions, please contact your Provider Relations representative.

Pre-Certification Spinal Fusion CPT Procedure Codes

CPT	Description
22532	Arthodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic
22533	lumbar
22534	thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)
22548	Arthodesis, anterior transoral or extraoral technique, Clivus-C1-C2 (atlas-axis), with or without excision of odontoid process
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); below C2
22556	thoracic
22558	lumbar
22585	each additional interspace (List separately in addition to code for primary procedure)
22590	Arthrodesis, posterior technique, craniocervical (occiput-C2)
22595	- Arthrodesis, posterior technique, atlas-axis (C1-C2)
22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment
22610	thoracic (with or without lateral transverse technique)
22612	lumbar (with or without lateral transverse technique)
22614	each additional vertebral segment (List separately in addition to code for primary procedure)
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar

22632	each additional interspace (List separately in addition to code for primary procedure)
22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments
22802	7-12 vertebral segments
22804	13 or more vertebral segments
22808	Arthrodesis, anterior, for spinal deformity, with or without cast; 2-3 vertebral segments
22810	4-7 vertebral segments
22812	8 or more vertebral segments

Builders Benefits Insurance (BBI) Update

HealthAmerica and Builders Benefits have terminated the agreement under which HealthAmerica administered the Builders Benefits' self-insured health benefits plan. As of September 1, 2010, the Builders Benefits self-insured product line will no longer exist.

Builders Benefits has selected another carrier to offer a fully insured product in central and western Pennsylvania. If you have questions, please call your Provider Relations representative at 800-788-5448 or Customer Service at 866-761-7448.

Multiple Procedure Reduction Effective July 1, 2010

Starting July 1, 2010, HealthAmerica will use the multiple procedure reduction claims edit to reimburse for multiple, medically necessary, high-tech radiology services. The edit will apply to multiple procedures within a single code family performed in a single session encounter.

The edit will be applied according to the Center for Medicare & Medicaid Services (CMS) claims-editing software guidelines.

Implementing this edit aligns HealthAmerica's payment policy with industry standards for radiology services. We are implementing the edit through our partnership with National Imaging Associates.

If you have any questions please call your provider relations representative. Thank you for continuing to support the HealthAmerica provider network.

Prior Authorization Requirements

As a reminder, HealthAmerica must *prospectively* review services requiring prior authorization *before* these services are provided to members. Prospective review is necessary to determine if the requested service is medically necessary and eligible for coverage under the member's benefit. The preauthorization list and guidelines for obtaining a prospective review are posted at www.healthamerica.cnty.com

Retrospective review applies only to services for emergent and urgent care when providers notify HealthAmerica within 48 to 72 hours after the service is provided. Services requiring prior authorization are not eligible for retrospective review. This includes elective/urgent hospitalizations, designated outpatient surgeries, complex diagnostic testing, and ancillary services.

Following prior authorization guidelines and timely notification allows the member to be appropriately advised of benefit coverage. Members should be aware of any potential financial responsibility before they receive services so they can make an informed decision to proceed with a noncovered service or to seek alternative options.

Requests to preauthorize services are reviewed according to regulatory requirements and are evaluated on medical necessity, level of service, date of service, proposed length of stay, and provider participation.

We appreciate your participation and continued cooperation in our efforts to provide excellent customer service to our providers and members.

For questions, please call Customer Service at 1-800-788-8445 in eastern Pennsylvania, 1-800-735-4404 in western Pennsylvania, and 1-800-290-0190 for Advantra

Coventry Health Care Introduces a Consolidated Emdeon Payer ID for Commercial and Medicare Plans

Effective December 1, 2009, Coventry Health Care is streamlining front-end EDI claim submissions by reducing the number of Emdeon payer IDs used for Commercial and Medicare/Advantra plans. Coventry has selected one of their existing Emdeon payer IDs to be the go forward consolidated payer ID - 25133, which is currently used for both Coventry Health Care of Kansas and Coventry Health & Life – Oklahoma. The new name for this payer ID is simply, Coventry Health Care.

Claims that were previously submitted for any of the Emdeon payer IDs below may now be submitted via payer ID 25133. Member ID cards published for 2010 and thereafter, will carry the new payer ID of 25133 for all applicable Coventry health plans. Coventry will continue to accept inbound EDI claim submissions via the legacy payer IDs as well as the new consolidated payer ID for a finite period of time.

Please contact your practice management vendor/billing service to confirm connectivity to payer ID 25133 and begin migrating applicable Coventry legacy payer IDs to 25133.

Acknowledgment and claim tracking reports for claims submitted via ID 25133 will now reference the name Coventry Health Care instead of the previous name of Coventry Health Care of Kansas. Coventry's claim routing and adjudication will continue as is and not be impacted in any way by this change.

PLEASE NOTE: In the future, all new Coventry health plans or products will be setup utilizing the consolidated payer ID 25133.

ERA changes due to Emdeon consolidated payer ID

Today, electronic remittance advices (ERAs) are distributed by Emdeon according to the Coventry payer ID of the adjudicating health plan. This individual payer ID delivery approach will continue until August 2010.

Beginning August 2010, Coventry will use the consolidated payer ID to deliver ERA files. These files will contain all ERA information for the Coventry commercial, Medicare/Advantra plans listed below, as well

as any Coventry plans added to the consolidated payer ID during 2010. Coventry will no longer produce separate ERA files for the individual legacy payer IDs.

To avoid ERA delivery interruptions, providers will need to verify they are enrolled for the Coventry consolidated payer ID 25133 with Emdeon, and make necessary updates with their practice/hospital management system or billing vendors to accommodate changes resulting from the delivery of Coventry ERA files via the new consolidated payer ID. *NOTE: Not all health plans will be included in each file due to variations in check processing schedules.*

25133 - COVENTRY HEALTH CARE

Legacy Payer IDs/Health Plans:

- 25126 - Health America/Health Assurance
- 25127 - Coventry Health Care of Georgia
- 25128 - Southern Health Services
- 25129 - WellPath
- 25130 - Coventry Health Care of Delaware
- 25132 - Coventry Health Care of Iowa
- 25133 - Coventry Health Care of Kansas
- 25133 - Coventry Health & Life - Oklahoma
- 25135 - Coventry Health Care of Louisiana
- 25136 - Coventry Health Care of Nebraska
- 25139 - Carelink
- 25141 - Group Health Plan
- 25141 - Coventry Health & Life - Tennessee
- 25146 - PersonalCare
- 25149 - Altius Health Plans
- 25149 - Coventry Health Care – Nevada
- 25152 - Advantra (Texas, New Mexico, Arizona)
- 25152 - Advantra Freedom/Advantra Savings
- 62413 - Associated Benefit Plan
- 62413 - Foreign Service Benefit Plan
- 62413 - Rural Carrier Benefit Plan
- 62413 - Mail Handlers Benefit Plan
- 87043 - Coventry Health Care National Network
- 87043 - Missouri Department of Transportation/MoDOT & Saint Louis University
- 87043 – University of Missouri

HEDIS 2010 Quick Reference Guide

Diagnosis and/or procedure codes to determine compliance with certain HEDIS measures

Breast Cancer Screening

Percentage of women 42-69 years who had a mammogram during the measurement year or the year prior

Diagnosis codes	V76.11, V76.12
Procedure codes	76090-76092, 77055-77057, G0202, G0204, G0206

Chlamydia Screening

Percentage of women 16-24 years who were identified as sexually active who had at least one test for Chlamydia during the year

Procedure Codes	87110, 87270, 87320, 87490, 87492, 87810
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Cervical Cancer Screening

Percentage of women 21-64 years who received 1 or more pap tests during the year or the 2 years prior to the measurement year.

Diagnosis codes	V72.32, V76.2
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Procedure codes	88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091
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Well Child Visit- First 15 months of life

Percentage of children who turned 15 months old during the year who had six or more well-child visits with a PCP or Pediatrician in their first 15 months of life

Diagnosis codes	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9
Procedure codes	99381, 99382, 99391, 99392, 99432, 99461

Well Child Visit- Third, Fourth, Fifth and Sixth years of life

Percentage of children ages 3-6 years who received one or more well-child visits with a PCP or pediatrician during the year

Diagnosis codes	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9
Procedure codes	99382, 99383, 99392, 99393

Adolescent Well Care Visit

Percentage of members ages 12-21 who had at least one comprehensive well-care visit with a PCP or OB/Gyn during the year

Diagnosis codes	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9
Procedure codes	99383-99385, 99393-99395

Diabetes Care

Percentage of members 18-75 with diabetes who had each of the following: HbA1C testing; eye exam; LDL-C; screening for diabetic nephropathy monitoring, & blood pressure reading.

Diagnostic Codes to identify Diabetes	250, 357.2, 362.0, 366.41, 648.0
HbA1c- procedure code	83036, 83037, 3044F, 3045F, 3046F
LDL-C Screening-procedure codes	80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F
Eye Exam- procedure codes	67028, 67030, 67031, 67036, 67038-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245, S0620, S0621, S0625, S3000, 2022F, 2024F, 2026F, 3072F
Eye Exam-diagnosis code	V72.0
Nephropathy Screening Tests (Urine micro and macro-albumin test)	82042, 82043, 82044, 84156, 3060F, 3061F
Blood Pressure Screening –Compliance	<130/80: Systolic 3074F, Diastolic 3078F <140/90: Systolic 3074F, 3075F, Diastolic 3078F, 3079F

Lead Screening in Children

Percentage of children 2 years of age who had 1 or more capillary or venous lead blood test for lead poisoning by their 2nd birthday.

Procedure codes	CPT 83655
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Adolescent Immunizations

Percentage of children age 13, who received the following vaccines: 1 meningococcal & 1 tetanus, diphtheria toxoids, acellular pertussis (Tdap), or 1 tetanus, diphtheria (Td).

Immunization	CPT Codes	
Meningococcal	90733, 90734	
TdaP	90715	
Td	90714, 90718	
Tetanus	90703	
Diphtheria	90719	

Postpartum Care

Percentage of women who had postpartum care on or between 21 & 56 days after delivery

Diagnosis codes	V24.1, V24.2, V25.1, V72.3, V76.2
Procedure codes	57170, 58300, 59400, 59410, 59430, 59510, 59515, 59610, 59614, 59618, 59622, 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175, G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091, 0503F

Prenatal Care

Percentage of pregnant women who received a prenatal care visit in the first trimester or within 42 days of enrollment

	Stand alone codes	Code Combinations*
Procedure Code (A)*		99201-99205, 99211-99215, 99241-99245
Procedure Code (B)*	59400, 59510, 59610, 59618, 59425, 59426, 0500F, 0501F, 0502F	76801, 76805, 76811, 76813, 76815-76818, 80055
Diagnosis (C)*		V22-V23, V28, 640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3.

*For code combination approach, must include one code from (A), and one code from (B) and one code from (C).

Childhood Immunizations

Percentage of children 2 yrs old who have received the following vaccinations: (4) DtaP/DT; (3) IPV; (1) MMR; (3) Hib; (3) Hep B; (1) VZV; (4) Pneumococcal conjugate; (2) Hep A; (2 or 3) Rotavirus; and (2) Influenza vaccines.

Immunization	CPT/HCPCS	Diagnosis codes*
DtaP	90698, 90700, 90721, 90723	
IPV	90698, 90713, 90723	
MMR	90707, 90710	
Measles and rubella	90708	
Measles	90705	055
Mumps	90704	072
Rubella	90706	056
HIB	90645- 90648, 90698, 90721, 90748	
Hepatitis B	90723, 90740, 90744, 90747, 90748, G0010	V02.61, 070.2, 070.3
VZV	90710, 90716	052, 053
Pneumococcal Conjugate	90669, G0009	
Hepatitis A	90633	070.0, 070.1
Rotavirus (2 dose schedule)	90681	
Rotavirus (3 dose schedule)	90680	
Influenza	90655, 90657, 90661, 90662, G0008	

*Indicates evidence of disease. A member who has evidence of disease during the numerator event time is compliant for the antigen.

Adult Body Mass Index (BMI) Assessment

Percentage of adults age 18-74 who had an outpatient visit during the measurement year or the year prior, and who had their BMI documented.

Codes to Identify BMI	Diagnostic Codes	HCPCS Codes
Body Mass Index (BMI)	V85.0 - V85.5	G8417 - G8420

Weight Assessment (BMI) & Counseling for Nutrition & Physical Activity for Children/Adolescents

Percentage of members age 2-17 who had an outpatient visit during the year, who had their BMI documented and counseling for nutrition and physical activity.

	Diagnostic Codes	Procedure Codes
BMI percentile	V85.5	
Counseling for nutrition	V65.3	97802-97804, G0270-G0271, S9449, S9452, S9470
Counseling for physical activity	V65.41	S9451

Pharmacy Update

Here are the actions taken at the Coventry Commercial Pharmacy & Therapeutics Committee meeting in March 2010.

Formulary Additions

The drugs in Table 1 have been added to the formulary effective immediately.

Table 1. Formulary Additions

Brand Name	Generic Name	Comment
Onglyza (ST)	saxagliptin	Alternative to Januvia (Tier Two). Both are considered

		as second or third line agents for diabetes
Ranexa	ranolazine	For chronic chest pain or angina
Wellbutrin XL*	bupropion ER	Available from multiple mfgs & reasonably priced

* generic available on Tier One

ST – Step Therapy on Standard List

Prior Authorization Additions – Non-Specialty Drugs

The drugs in Table 2 were reviewed and will require prior authorization under our Standard and Select Prior Authorization programs.

Table 2. Prior Authorization Additions with Alternatives

Agent	Tier	Formulary Alternatives / Comments
Fanapt (PA)	3	Risperdal*(Tier One), Seroquel (XR) (Tier Two). There is no data to distinguish Fanapt as superior to the other atypical antipsychotics
Victoza (PA)	3	Byetta (Tier Three). Both are considered as third line agents for diabetes

* generic available on Tier One

PA – Prior Authorization req'd

Prior Authorization Additions – Specialty Drugs

The drugs in Table 3 were reviewed and will require prior authorization under our Standard and Select Prior Authorization programs and are limited to distribution from our contracted Specialty Pharmacy.

Table 3. Prior Authorization Additions with Alternatives

Agent	Tier	Formulary Alternatives / Comments
Ampyra (PA/SP)	3	Indicated to improve walking in patients with multiple sclerosis (MS). Note that this drug is added to and does not replace the injectable drugs that MS patients use to reduce frequency of relapses
Cayston (PA/SP)	3	TOBI (PA/SP). For cystic fibrosis patients who have certain bacteria present in their lungs
Chenodal (PA/SP)	3	For the diagnosis of a rare condition called cerebrotendinous xanthomatosis (CTX) or for translucent gallstones in patients with a high-risk for surgery

PA – Prior Authorization req'd

SP – Limited to Specialty Pharmacy for supply

Prior Authorization/ Step Therapy Additions

The drugs in Table 4 were reviewed and prior authorization criteria were removed based on supporting clinical evidence.

Table 4. Prior Authorization Criteria change to Step Therapy / Unrestricted

Agent	New Status	Comments
Accutane*	Step therapy	Review pharmacy fill data for minocycline and doxycycline as well as treatment duration of Accutane
Actos	Step therapy	Including ACTOplus Met and Duetact. Review pharmacy fill data for appropriate duration and dose of metformin use
Avandia	Step therapy	Including Avandaryl and Avandamet. Review pharmacy fill data for appropriate duration and dose of metformin use
Januvia	Step therapy	Including Janumet. Review pharmacy fill data for appropriate duration and dose of metformin use
Onglyza	Step therapy	Review pharmacy fill data for appropriate duration and dose of metformin use
Apokyn (SP)	Unrestricted	For Parkinson's disease
Caverject / Edex	Step therapy	Review pharmacy fill data for Viagra or Cialis or Levitra. No longer limited to specialty pharmacy for supply.
D.H.E. 45	Unrestricted	For migraine headache. No longer limited to specialty

		pharmacy for supply.
Fuzeon (SP)	Unrestricted	For HIV infection
Ranexa	Unrestricted	For chronic chest pain or angina
Rhogam	Unrestricted	Including HyperRho and WinRho. In addition to coverage under medical benefit, it is now available under pharmacy benefit

* generic available on Tier One SP – Limited to Specialty Pharmacy for supply

Other Actions/Information

The following formulary position was approved.

P&T approved a new policy on **off-label use** and this will replace Tec Assessments for drugs. The Off-Label Policy is used when the prior authorization criteria do not address the specific requested use of the medication and provide a path to assure that we apply an evidence based approach to reviewing the request. This policy is designed to produce a consistent and thorough review process across all plans/regions regarding the use of a medication which falls outside the usual and customary coverage policy.

Important Billing Information for Members with Health Accounts

HealthAccounts include FSAs, HRAs, and HSAs

Some members use medical savings accounts, including flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), and health savings accounts (HSAs), to pay for qualified health care expenses. These are member- or employer-funded accounts that encourage members to become active participants in their health care. Coventry encourages members to seek appropriate medical care and to work closely with their providers when receiving medical care.

We also appreciate your need for prompt payment for services. To help ensure timely, accurate payment of claims, we ask that you do the following:

1. Check the patient's ID card and verify FSA, HRA, or HSA participation by calling the number on the ID card or verifying online.
2. Before you ask a patient for payment, submit claims to the address on the back of the ID card.

We will process the claim and pay it from the member's account. If the patient/member owes a balance to you, we will send an Explanation of Benefits (EOB) notifying you and the member of the amount owed. We may also send you a payment directly out of the members account for any member responsibility. If you have already collected payment from the patient you may need to refund an overpayment. You may also send a bill to the member with the amount due.

We are committed to paying claims promptly and correctly. If you have questions or need further assistance, please call us at the number on the back of the member's ID card.

Need Help? Turn to our Website (www.healthamerica.cvty.com)

Click *Providers* then choose *Document Library* to learn more about the following:

- Access standards
- Confidentiality policy
- Pregnancy assessment form
- Practice safety assessment form
- CT scan worksheet
- New therapy progress worksheet
- Medical record review policy and guidelines
- Clinical Practice Guidelines (Provider)

- ADHD
- Asthma
- Bipolar Disease
- Congestive Heart Failure
- Coronary Artery Disease
- Depression
- Diabetes
- Osteoporosis (Adult)
- Clinical requirements, reference, and worksheets (for providers)
- Pharmacy forms (for providers)

Click *Plan Members* then choose *Other Important Information* to learn more about the following:

- Advance Directives (“Living Wills”) for Health Care in Pennsylvania and Ohio
- Filing a complaint or appeal (both in Ohio and Pennsylvania)
- Finding a network health care professional
- How to contact us
- Information about our case and disease management programs
- Information about the national Leapfrog hospital safety survey
- Member rights and responsibilities
- Notice of privacy practices
- Obtaining care when outside the service area
- Obtaining emergency care
- Pennsylvania health care cost containment council
- Precertification requirements
- Quality and Compliance, including a description of the QI process and the QI newsletter
- Receiving primary care
- Reviewing the prescription drug formulary and changes to the formulary
- Standards HealthAmerica network providers must meet, including after hours coverage
- Submitting a claim form for covered services (member)
- What Utilization Management is and how decisions are made
- How to reach Utilization Management and how to obtain UM criteria
- Results of new technology assessments

If you do not have Internet access, call your Provider Relations representative to receive a copy of the newsletter or any of the documents on our website via U.S. mail.

HEDIS 2010 Results (2009 rate)

This year HealthAmerica reported three HEDIS reports: a commercial HMO/POS and two Medicare reports. We have continued to make strides in increasing the preventative services that our members are receiving. In most of our HEDIS measures we have either continued to do well or increased our rates.

WE also recognize that without the physician provider community we would not be successful at keeping our members healthy. We would like to **thank you** for all the hard work and time that each and every one of you put into the care of our mutual members.

Please see below for a snapshot of our current HEDIS rates. Please keep in mind that HEDIS data is at least one year old, so the data and rates below reflect activities that occurred in the year 2009 or back. HEDIS data is submitted yearly to NCQA in June of the reporting year by product line of business, therefore in June of this year we submitted data claims 2009 and back.

If you have any questions or comments regarding HEDIS and our HEDIS rates, please contact Janae Smith at (412) 553- 7355.

HEDIS 2010-(2009 Rates):

HMO/POS	2003 HMO/POS rate	2004 HMO/POS rate	2005 HMO/POS rate	2006 HMO/POS rate	2007 HMO/POS rate	2008 HMO/POS rate	2009 (HEDIS 2010) HMO/POS
Persistence of Beta Blocker Treatment	N/A	73.38%	75.54%	66.78%	71.72%	77.8%	80.99%
Breast Cancer Screening	85.39%*	82.77%	71.51% **	67.32%	70.15%	71.60%	71.54%
Cervical Cancer Screening	91.71%	93.59%	93.59%	94.44%	94.44%	94.39%	75.62%**
Cholesterol Screening after a cardiac event	85.13%	85.13%*	85.39%	92.79%	92.08%	92.08%	95.72%
Cholesterol Management Level <100mg/dl after a cardiac event	N/A	N/A	N/A	60.23%	66.09%	66.09%	81.55%
Diabetic Eye Exam	65.43%	67.74%	67.74%	69.72%	70.36%	70.36%*	73.47%
Diabetic HBA1c Screen	90.02%	95.39%	95.39%*	93.90%	93.25%	93.25%*	96.51%
Diabetic HBA1c Poorly Control (lower the better)	25.06%	22.81%	22.81%*	20.66%	21.93%	21.93%*	13.44%
Diabetic LDL Screen	94.66%	95.62%	95.62%*	94.84%	94.94%	94.94%*	94.94%
Diabetic LDL Level <100 mg/dl	N/A	N/A	N/A	57.75%	53.73%	53.73%*	66.67%
Diabetic Nephropathy	67.98%	68.89%	68.89%	78.17%	85.06%	85.06%*	89.53%
Controlling High Blood Pressure	68.03%	73.17%	73.17%	75.23%	74.78%	78.93%	78.93%*
Childhood immunization status-combo II	81.07%	81.07%*	86.51%	86.51%*	85.32%	85.32%*	85.16%

Adolescent Immunization status-Combo II	73.83%	73.83%*	79.23%	79.23%	N/A*	N/A*	54.85%**
Use of Spirometry testing in the assessment and treatment of COPD	N/A	N/A	N/A	32.65%	49.48%	39.65%	50.32%
Use of Appropriate medications for Asthma (combo)	76.17%	76.22%	90.7%**	91.37%	93.36%	94.67%	95.88%
Adult BMI Assessment	N/A	N/A	N/A	N/A	N/A	N/A	51.56%

* Measure rotated use previous years rate.

** Specification change- admin/claims only data

Medicare HMO (H3959)

	2003 RATE	2004 RATE	2005 RATE	2006 RATE	2007 RATE	2008 RATE	2009 RATE (HEDIS 2010)
Persistence of Beta Blocker	N/A	74.74%	72.73%	74.87%	80.54%	82.68%	83.91%
Breast Cancer	85.29%	83.75%	68.37%	68.53%	68.28%	69.38%	69.47%
Cholesterol Screening after a cardiac event	84.23%	89.66%	89.04%	93.50%	94.15%	94.50%	96.06%
Cholesterol Screening level <100mg/dl after a cardiac event	N/A	N/A	N/A	68.68%	75.80%	74.62%	76.80%
Diabetic Eye Exam	77.90%	76.68%	76.51%	79.86%	79.25%	84.20%	82.56%
Diabetic HBA1C Testing	88.38%	93.95%	94.18%	96.21%	95.80%	97.09%	94.88%
Diabetic HBA1c Poorly controlled (lower the better)	21.18%	14.35%	14.99%	13.51%	11.66%	11.35%	13.02%
Diabetic LDL Screen	93.62%	95.29%	95.75%	95.50%	93.47%	92.64%	94.65%
Diabetic LDL level 100 mg/dl	N/A	N/A	N/A	66.35%	64.10%	65.95%	73.02%
Diabetic Nephropathy	68.79%	71.75%	70.92%	85.78%	88.81%	93.56%	90%
Controlling Hypertension	66.28%	75.12%	75.15%	75.50%	75.07%	80.06%	78.72%
Osteoporosis screening	21.85%	18.97%	25.48%	20%	31.22%	33.29%	35.07%
Use of Spirometry testing in the assessment and treatment of COPD	N/A	N/A	N/A	27.29%	36.10%	34.98%	44.19%
Adult BMI Assessment	N/A	N/A	N/A	N/A	N/A	29.17%	62.04%