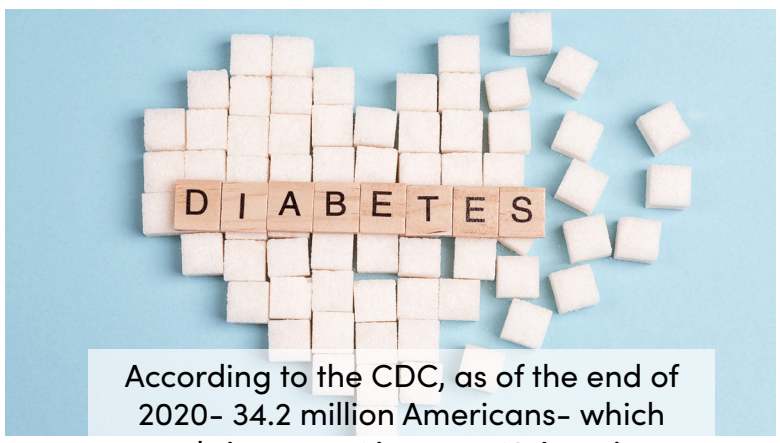
HEALTH | CHOICE
UTAH

HEALTH | CHOICE
GENERATIONS

PROVIDER NEWSLETTER

January 2022

INSIDE THIS ISSUE



According to the CDC, as of the end of 2020- 34.2 million Americans- which equals just over 1 in every 10 American, have a form of diabetes.

ANNOUCEMENTS

2021 brought many exciting changes to Health Choice Utah (Medicaid) and Health Choice Generations (Medicare). We have new office space, updated equipment and have migrated to several new software platforms to improve our efficiency and outcomes in interacting with our members and providers. The past several months have brought successful transitions on our Health Choice Utah line of business to new provider demographics and claims processing software and a new provider portal.

The start of 2022 will see some additional changes as well. Here are some key changes for our provider network to take note of:

- Effective 1/1/2022, Health Choice Generations transitioned to a new claims platform. The only major alteration this has in providers submitting claims is that our Health Choice Generations Payer ID will be rolled in with our HCU Payer ID. Therefore, both lines of business will utilize 45399 as their Payer ID.
- In conjunction with the new claims system, Health Choice Generations providers will utilize our new HealthTrio Provider Portal to view claim status and EOBs. To register for access, please email provider.portal@healthchoiceutah.com.
- Effective 1/1/2022, Health Choice Utah will switch to a new Pharmacy Benefit Manager (PBM), RealRx. Please see RxBin and contact information found in the section below.

As always, please do not hesitate to reach out to your Provider Services Representative with any questions or concerns that arise from these changes. We also have a general email inbox you can email if you are unsure who your designated Rep is: providers@healthchoiceutah.com.

CONTACT INFORMATION

GENERAL INFORMATION

Health Choice Utah – Medicaid
Member Services: (877) 358-8797
Prior Authorizations Fax: (877) 358-8793
www.healthchoiceutah.com/
PAYER ID: 45399

Health Choice Generations D-SNP – Medicare
Member Services: (844) 457-8943
Prior Authorizations Fax: (844) 457-8942
www.healthchoicegenerations.com/utah/
PAYER ID: 45399

CLAIMS ADDRESS

Health Choice Utah (or)
Health Choice Generations
PO Box 45900
Salt Lake City, UT 84145

HEALTH CHOICE UTAH - PBM

RealRx Pharmacy Help Desk:
(855) 864-4046
RXBIN: 610830
RXPCN: RRXHCU
RXGRP*: N/A

PROVIDER PORTAL HELP

Provider.Portal@healthchoiceutah.com

PROVIDER SERVICES

Steve Baker – Network Director: (801) 646-7272
Chase Montgomery - Representative: (801) 646-7294
Nicole Gilliam - Representative: (801) 646-7276
Troy Fuller - Representative: (801) 646-7275
Kayanne Malin - Representative: (801) 646-7277
Providers@healthchoiceutah.com

QUALITY / RISK ADJUSTMENT

Rachel Vasquez – Quality Manager: (801) 646-7285
Jessica Hocker - Risk Coding Auditor: (801) 646-7283
DeAnn Andreason - QI Specialist: (801) 646-7280
Polly Davidson - QI Specialist: (801) 646-7281
Monique Hall - QI Specialist: (801) 646-7282
Vickie Jenkins - QI Specialist: (801) 646-7284

DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT (DSMES)

Finding Success with DSMES

The purpose of DSMES is to give people with diabetes the knowledge, skills, and confidence to accept responsibility for their self-management. This includes collaborating with their health care team, making informed decisions, solving problems, developing personal goals and action plans, and coping with emotions and life stresses.

Diabetes Self-Management Education & Support is a covered benefit under most insurances, including Medicaid and Medicare.

Visit https://heal.health.utah.gov/diabetes/ for more information on a list of DSMES providers in Utah and educational handouts.

4 Critical Times to Refer to DSMES

Providers should initiate referral and facilitate participation in DSMES at these four critical times:

1. Upon diagnosis
2. Annually and/or when not meeting treatment targets
3. When complicating factors develop
4. When transitions in life and care occur

LIVING WELL WITH CHRONIC CONDITIONS

Living Well Utah Contact Information:
(888) 222-2542 – livingwell@utah.gov

The Living Well with Chronic Conditions Program offers weekly workshops in local community settings. The workshops are about 2 ½ hours, once a week for 6 weeks. Anyone with an ongoing condition can come.

Chronic conditions addressed include:

- Asthma
- Arthritis
- Chronic Joint Pain
- Fibromyalgia
- Cancer
- Diabetes
- Kidney Disease
- High Blood Pressure
- High Cholesterol
- Heart Failure
- COPD or Emphysema
- Depression
- Other Chronic Conditions
- PRN

Subjects covered include:

- Techniques for frustration, fatigue, pain and isolation
- Appropriate exercise to maintain and improve strength
- Appropriate use of medications
- Good nutrition
- Communicating effectively with family, friends and health professionals
- How to evaluate new treatments

IDENTIFYING BARRIERS TO REFERRALS AND TREATMENT

Provider-level barriers to referrals may include:

1. Unfamiliarity with the DSMES program
2. Lack of availability of local DSMES services
3. Confusion about referrals and daunting referral paperwork
4. Concerns about insurance issues or cost to the person with diabetes

Using technology can help healthcare providers identify their patients with diabetes and increase referrals to DSMES. Healthcare providers can use functions of the electronic health record (EHR) to identify people with diabetes who can benefit from DSMES. EHRs can be used to:

- Generate and track referrals
- Identify people with diabetes in need of additional follow-up
- Close referral loops between providers and DSMES services

OVERCOMING BARRIERS

Training clinic staff to proactively contact patients with diabetes every 3 months for follow-up care can help increase patient compliance and reduces the chances of additional chronic conditions emerging.

To do this, staff should:

- Monitor HbA1c every 3 months
- Monitor blood pressure
- Ensure eye exams are being completed
- Follow-up with eye care providers for results of dilated retina exams and ensure records are being received and uploaded to the patients record
- Kidney function test at least once per year

DETAILED AND ACCURATE DOCUMENTATION – WHY IT MATTERS

Accurately documenting chronic conditions associated with a patient's diabetes can help improve collaboration between the PCP and other specialists, ultimately improving the care a patient receives.

This information gives insurance companies a better indication of a patient's needs or potential needs regarding Case Management, DME, laboratory supplies, and/or medications.

HbA1c:

At a minimum, documentation in the medical record must include a note indicating the date when the most recent HbA1c test was performed and the result.

Diabetic Eye Exam Criteria:

A retinal dilated eye exam by an eye care professional (optometrist or ophthalmologist) during the current measurement year.

A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist, prior year and/or current year.

Bilateral eye enucleation any time during the member's history through December 31 of the current year.

Closing the referral loop:

PCPs have noticed a decrease in medical record receipt from specialist offices.

Part of this may be due to self-referrals or lack of communication with a patient to obtain their PCP information when being seen for their appointment.

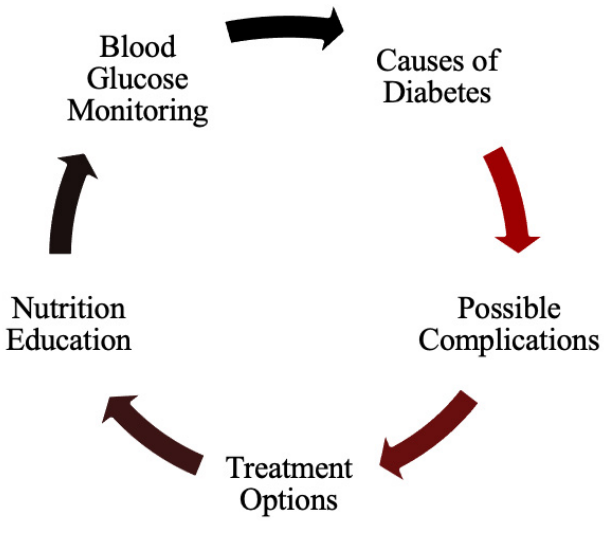
Some PCP offices have developed a "Medical Home" program to help track referrals and ensure that medical records are received. It is important the PCP has an opportunity to review these medical records to maintain the best quality of care and patient safety.

Please ensure your clinic has a process in place for requesting and uploading these records into your EHR. Reminding patient's to notify their Specialist of who their PCP is will help close the gap in records not being received.

BEST PRACTICE GUIDELINES AND PROCESS IMPROVEMENT

Provider Education

A patient's initial diabetic diagnosis is most likely to come from their primary care provider. A new diagnosis of diabetes can be a very confusing time for patients as much of their lifestyle needs to be adjusted to manage their diabetes and control progression. Providers should explain the basics and allow plenty of time to address any questions or concerns, such as:



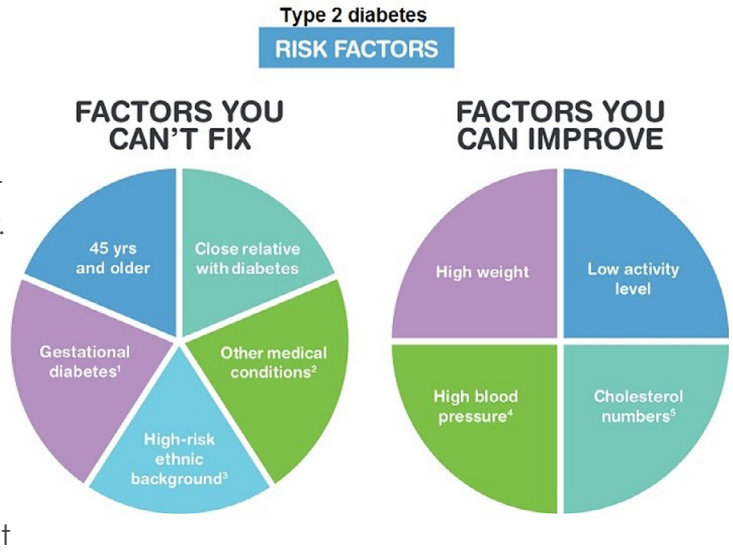
Diabetes Awareness Tips

- Diabetes can be caused by many factors— it's not always due to lifestyle choices.
- No need for panic—there are ways to reduce the risk of complications.
- People with diabetes do not need special foods—they just need to be more aware of the type and amount of food they consume. (Controlling carbohydrates, portion sizes, and fat and salt intake but also enjoying the occasional sweet treat.)
- Being active helps—the person with diabetes should think of ways to be more active.
- Learning to master diabetes is critical—it can be helpful to see a diabetes educator.
- The person with diabetes is not alone—though a diabetes diagnosis can be overwhelming, the referring provider and other health care providers are there to help.

It is unrealistic to expect people with diabetes to make lifestyle changes without access to services.

Type 2 Diabetes Risk Factors

Referring providers should inform patients with diabetes of the option for a DSMES referral. DSMES services are one of the tools that can help them be successful in managing the disease. It is also helpful to encourage DSMES participation and let people with diabetes know that others who have attended DSMES services have learned how to successfully manage their diabetes.



WHO SHOULD BE PRESCRIBED A STATIN?

In 2013, a joint task force of the American College of Cardiology and the American Heart Association released guidelines for treating cholesterol. These guidelines focused on treating the patient, based on his or her risk of developing heart disease. The guidelines, which were updated in November 2018 and published in the journal, Circulation, now emphasize a balance between LDL numbers and assessing cardiovascular disease. For drug therapy, statins remain the first-line of defense for patients who are at high risk for a cardiovascular event.

The first step in preventing or treating high cholesterol is with diet and lifestyle changes. We know these changes can be difficult to make, but statin therapy is not an alternative to healthy eating and exercise. Instead, it's an added preventive measure. There are four general categories recommended to determine who is at high risk for a cardiovascular event, such as a heart attack or stroke. Use the American Heart Association's heart disease risk calculator to start a conversation with your patient about their risk.

Patients who are at a high risk for a cardiovascular event:

1. Have clinical atherosclerotic cardiovascular disease (ASCVD), including those with a personal history of stroke, heart attack, or peripheral vascular disease, and also those who suffer from chest pain (angina)
2. Have extreme elevations in cholesterol (an LDL cholesterol of 190 mg/dL or higher)
3. Are age 40 to 75 and have diabetes
4. Are age 40 to 75 and have an estimated 10-year risk of an ASCVD event greater than 7.5 percent.

KDIGO Heat Map

Risk of progression by intensity of coloring + Guide to frequency of monitoring (number of times per year) + Referral decision making by GFR and albuminuria category				Persistent albuminuria categories, Description and range		
				A1	A2	A3
				Normal to mildly increased	Moderately increased	Severely increased
				<30 mg/g <3 mg/mmol	30-300 mg/g 3-30 mg/mmol	>300 mg/g >30 mg/mmol
GFR categories (ml/min/ 1.73 m²), Description and range	G1	Normal or high	≥90	1 if CKD	1 Monitor	2 Refer
	G2	Mildly decreased	60-89	1 if CKD	1 Monitor	Refer
	G3a	Mildly to moderately decreased	45-59	1 Monitor	2 Monitor	3 Refer
	G3b	Moderately to severely decreased	30-44	2 Monitor	3 Monitor	3 Refer
	G4	Severely decreased	15-29	3 Refer	3 Refer	4+ Refer
	G5	Kidney failure	<15	4+ Refer	4+ Refer	4+ Refer

(KED) KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES

Evidence shows that contrary to clinical guidance, fewer than half of the people with diabetes receive an annual kidney assessment that includes both eGFR and uACR. Kidney Health Evaluation for Patients with Diabetes (KED) addresses this gap.

The specifications for KED include patients 18-85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR).

Complete and accurate documentation, along with proper coding can improve care coordination, care planning, inclusion in patient registries and population management.

REFERENCES

1. (2020, February) National Diabetes Statistics Report, 2020. https://www.cdc.gov/diabetes/library/features/diabetes-stat-report.html
2. (2021, November) Find Success With DSMES Services. https://www.cdc.gov/diabetes/library/features/dsmes-success.html
3. (2020, November) Diabetes Management and Prevention. https://heal.health.utah.gov/diabetes/
4. (2020, November) Diabetes Management. https://heal.health.utah.gov/dsmes/
5. (2021, October) Diabetes Self-Management Education and Support Toolkit Referral Process. https://www.cdc.gov/diabetes/dsmes-toolkit/referrals-participation/referral-process.html
6. (2019, April) Who should be prescribed a statin? https://www.Utswmed.org/medblog/statins-debate/
7. (2020, March) Living Well With Chronic Conditions. http://livingwell.utah.gov