MOLINA® HEALTHCARE

Provider Newsletter

July 2011

NEW 2011 Tdap Immunization Requirement 7th-12th GRADE

A new school immunization law requires all students entering 7th through 12th grades in the 2011-2012 school year in California to be immunized with a pertussis (whooping cough) vaccine booster called Tdap.

Pertussis is a very contagious respiratory disease that can be severe and last for months. The immunity received from either early childhood immunization or pertussis disease wears off over time, leaving older students and adults susceptible again to pertussis. Immunization with Tdap can protect students, schools and communities against pertussis.

The new requirement affects all students – current, new, and transfers – in public and private schools. The law has two phases:

- For the 2011-2012 school year, all students entering into 7th, 8th, 9th, 10th, 11th or 12th grades will need proof of a Tdap shot before starting school.
- For 2012-2013 and future school years, all students entering into 7th grade will need proof of a Tdap shot before starting school.

California's parents are being urged not to wait for the new fall school year, since there will be no grace period. Under the new law, students will not be allowed to start school without proof of vaccination.

In addition to Tdap, there are several important vaccines recommended for preteens and teens including the meningococcal vaccine, a second chickenpox shot (if they never had chickenpox disease), and the HPV vaccine series. Everyone older than 6 months old is also recommended to receive a seasonal flu vaccine.

For more information, please visit the *California Department of Public Health, Immunization Branch* http://www.cdph.ca.gov/programs/immunize/Pages/CaliforniaImmunizationSchoolLaw.aspx

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Weight Assessment, Counseling for Nutrition and Physical Activity For Children And Adolescents

HEDIS (Healthcare Effectiveness Data and Information Set) has performance outcome measures focusing on obesity in children and adolescents. Weight Assessment, Counseling for Nutrition and Physical Activity:

- Assesses how consistently physicians perform BMI assessments among children and adolescents.
- Tracks counseling for nutrition and physical activity.

BMI Assessment:
Annual documentation of:

- BMI percentile or
- BMI percentile plotted on age-growth chart
- For adolescents 16-17 years, documentation of a BMI value expressed as kg/m2 is acceptable

Counseling for Nutrition:
Annual documentation of at least one of the following:

- Engagement in discussion or current nutrition behaviors (example: eating habits, dieting behaviors)
- Checklist indicating nutrition was addressed
- Counseling or referral for nutrition education
- Member received educational materials on nutrition
- Anticipatory guidance for nutrition

Counseling for Physical Activity:
Annual documentation of at least one of the following:

- Engagement in discussion of current physical activity behaviors (e.g. exercise routine, participation in sports activities, exam for sports participation)
- Checklist indicating physical activity was addressed
- Counseling or referral for physical activity
- Member received educational materials on physical activity
- Anticipatory guidance for physical activity

To simplify and assist in the identification and documentation of BMI and nutrition and physical activity counseling, some enhancements were made to the CDC's Body Mass Index -for-age percentile growth charts. The classifications of BMI percentiles were highlighted for ease in identification. ***Two columns were also added for quick documentation of nutrition and physical activity counseling by the provider.*** Molina hopes this tool will be useful in the accurate and timely documentation of BMI and nutrition and physical activity counseling in children and adolescents.

Please go to http://www.molinahealthcare.com/medicaid/providers/ca/forms/Pages/fuf.aspx to print copies from our website.

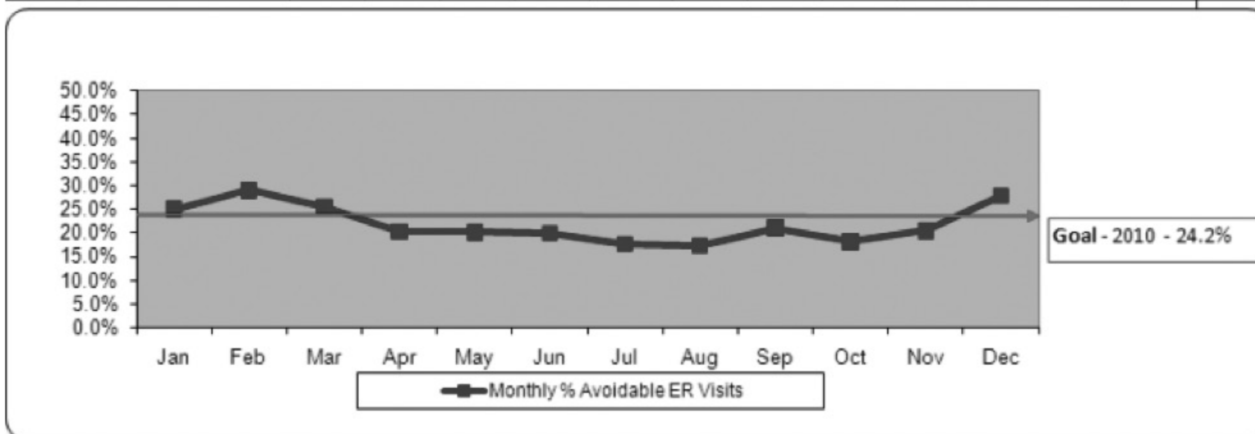
Emergency Room Collaborative

Molina Healthcare of California (MHC) partnered with primary care providers (PCP) in educating patients about the appropriate use of the emergency room (ER), URI preventions and self management to reduce avoidable ER visits. The focus of the ER collaborative health education campaign are members age 1-19 years in which 74% of the avoidable ER visits in Medi-Cal managed care are due to upper respiratory infections (URI), Pharyngitis or earaches.

Avoidable emergency room visit is defined by the Department of Health Care Services (DHCS) as "a visit which could have been more appropriately managed and/or referred to a primary care provider in an office or clinic setting". The DHCS designated avoidable ICD-9 diagnosis codes are used to define 'avoidable' visits. The 2010 Avoidable ER Visits include data from San Bernardino, Riverside, San Diego and Sacramento counties.

Molina Healthcare of California | **Age 1 - 19** | **All Counties**

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Goal
2010 ER Visits	3,966	4,296	4,111	3,510	3,955	3,469	3,461	3,708	3,949	3,956	4,084	4,182	
Avoidable ER Visits	993	1,247	1,046	709	798	691	614	644	832	720	837	1,165	
Monthly % Avoidable ER	25.0%	29.0%	25.4%	20.2%	20.2%	19.9%	17.7%	17.4%	21.1%	18.2%	20.5%	27.9%	24.2%



The 2010 flu season has been mild. There was sporadic influenza activity with minimal influenza-like-illness (ILI) in California according to CDC reports. The increase in the percentage of outpatient visits for ILI was influenced in part by a reduction in health care visits during the holiday season, as has occurred in previous seasons.

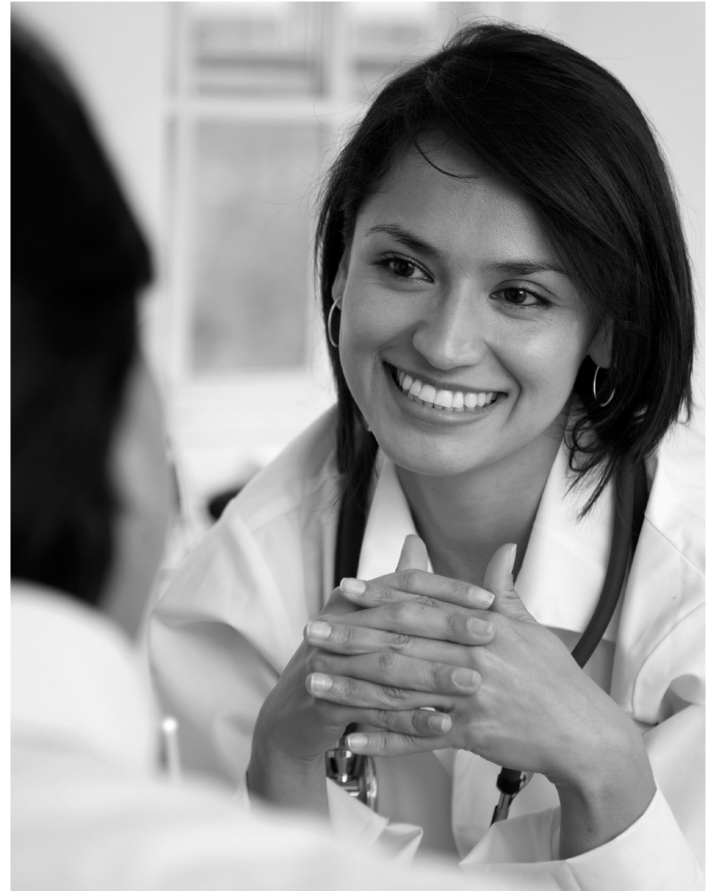
Activities to reduce avoidable ER visits:

- Case Management and Quality Improvement outreach to providers and members
- UM expanded outreach calls to members with ER visits in all counties
- ER health education brochures and posters available at PCP offices
- Hospital ER Collaboration
- Member mailing and distribution of "How to Take Care of your Sick Family" booklet
- Molina Medical Group ER follow up call initiative

Keep up the good work!

If you have any questions, please contact Quality Improvement at 800-526-8196, extension 126137.

Interpreter Services



The provision of high quality interpreter services can greatly improve the communication and care provided to patients with limited English proficiency. California law requires that health plans and insurers offer interpreter services to both limited English proficient (LEP) members and health care providers. Molina Healthcare of California (MHC) offers interpreter services to you and your MHC patients at no cost.

Face to Face Interpreter Services

In an effort to streamline this process, MHC is changing the way these services are requested and scheduled. Effective April 1, 2011 providers and members may request face to face interpreter services by calling our Member Services Department at 888-665-4621. If provider offices prefer to fax requests, they may be faxed to the Member Services fax at 562-901-9632. A prior authorization is no longer needed for this service, as our Member Services representatives will arrange for an interpreter.

How much lead time is necessary?

We recommend that provider offices give us at least 3 business days (72 hours) notice so that our interpreter agencies can identify an interpreter for the appointment. While Spanish interpreters are in plentiful supply, other languages, such as Farsi and Arabic, can sometimes be difficult to find on short notice. Sign language interpreters are also in high demand and require as much advance notice as possible. Molina cannot guarantee the availability of an interpreter at all times, however we will try our best to have an interpreter at the patient's appointment.

Telephonic Interpreter Services

For telephonic interpreter services, please contact MHC's Member Services Department at 888-665-4621. Patients who are deaf or hard of hearing, may call MHC's Member Services Department's TDD/ TTY line directly at 800-479-3310. To reach patients who are deaf, hard of hearing, or have a speech impairment you may dial 711 to use the California Relay Service. You will give the Relay Operator/Communication Assistant the patient's area code and phone number and they will connect and communicate via the patient's preferred type of communication (TTY, VCO, Internet, ASCII, etc.).

It is our hope that these changes will encourage our MHC providers to utilize interpreter services if they are not already doing so. MHC discourages the use of family members, minors and friends to interpret. We have made arrangements with our interpreter services vendors to send invoices directly to MHC for payment.

If you would like additional information about MHC's interpreter services, please contact MHC's Cultural and Linguistic Specialist at (562) 499-6191 ext. 127421.

NEW! Cholesterol Clinical Practice Guidelines

The Cholesterol Clinical Practice Guidelines for Adults and Pediatrics were adopted at the December 2010 Molina Healthcare of California (MHC) Clinical Quality Management Committee meeting.

- **Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) - NHLBI**
- **Lipid Screening and Cardiovascular Health in Childhood – American Academy of Pediatrics**

To view the Cholesterol Guidelines, visit MHC's website at: **www.molinahealthcare.com/medicaid/providers/ca/resource/Pages/guide_clinical.aspx**

To request a copy of these guidelines, please contact the MHC Provider Services Department at (888) 665-4621.

To view the preferred cholesterol lowering medications on the MHC Formulary, visit our website at: **www.molinahealthcare.com/medicaid/providers/ca/drug/Pages/formulary.aspx**

MHC offers **Healthy Living with Diabetes**sm and **Heart-Healthy Living** (cardiovascular) disease management programs for members. If you would like to refer a member, or would like information on these programs, please contact the MHC Health Education Department at **800 526-8196** ext. **127532**.

NEW! Cholesterol Management Clinical Practice Guideline Study

Statewide MHC HEDIS 2009 and 2010 results for Cholesterol Screening and LDL Control were well below the NCQA 75th percentile benchmarks (shown below):

Molina Healthcare of California HEDIS Cholesterol Screening and LDL Control - Statewide			**NCQA 2010 Benchmarks**
Cholesterol Measures	**2009**	**2010**	**NCQA 75th**
LDL Screening for patients with Diabetes	72.40%	76.51%	79.5%
LDL level < 100mg/dL for patients with Diabetes	**32.45%**	**32.53%**	**40.6%**
LDL Screening for patients with Cardiovascular Disease	76.32%	75.50%	85.2%
LDL level < 100mg/dL for patients with Cardiovascular Disease	**37.72%**	**34.43%**	**48.6%**

MHC conducts **clinical studies** to measure performance against selected clinical practice guidelines. The goals of the studies include improving quality of health care for our members and providing physician education. Beginning the 1st Quarter of 2011, a Cholesterol Management Clinical Practice Study will be conducted (on a quarterly basis) to measure cholesterol lowering medication treatment for members with Diabetes and/or Cardiovascular Disease having an LDL lab result ≥ 100mg/dL during the quarter.

Study interventions will include:

- Faxed letters to practitioners, identifying their members who may need additional follow-up.
- Educational postcards regarding cholesterol will be mailed to the members at the same time.

Study results will be published annually in future editions of the QI Provider Newsletter.

New Tuberculosis (TB) Recommendations

Tuberculosis (TB) remains a significant public health problem in California. In 2009, 2,472 cases of TB disease were reported in California; 71 of the reported cases were in children under 5 years of age. TB rates among children under 5 years of age are 5-11 times greater among Asian/Pacific Islanders, Hispanics, and Black non-Hispanics compared to White non-Hispanics[1].

TB infection may manifest as TB disease or Latent Tuberculosis Infection (LTBI). LTBI is a condition in which a person is infected with M. tuberculosis, does not currently have active TB disease, but is at risk of progression to active disease. Individuals with LTBI are asymptomatic and not infectious.[2] The most important steps to reducing the number of children with TB disease are prompt and thorough contact investigation of persons with known or suspected TB and active monitoring of infected contacts until completion of treatment.

SCREENING REQUIREMENTS*

- Assess all children for risk of exposure to tuberculosis at each health assessment visit.
- For children who are at increased risk of acquiring LTBI (including those with a positive Risk Assessment Questionnaire* and recently incarcerated adolescents), test for TB.
- For children who are more likely to progress to active TB if exposed (HIV, organ transplant, or other condition associated with significant immunosuppression), test for TB.
- The *only* contraindication to the Tuberculin Skin Test(TST) is history of a severe reaction (e.g., necrosis, blistering, anaphylactic shock, or ulcerations) to a previous TST[3].
- Read the TST 48 to 72 hours after placement and record the results in millimeters (mm) of induration, not erythema. Measure the diameter of the induration transversely to the long axis of the forearm.
- If the child fails to return for the scheduled reading:
    - **Only** a positive reaction may still be measured up to one week after testing.
    - Repeat the TST if no positive reaction can be measured when the child does return.

CONSIDERATIONS FOR REFERRAL, TREATMENT, AND/OR FOLLOW-UP*

- Refer any child for diagnosis and treatment who has symptoms consistent with active TB disease regardless of the test results.
- Evaluate all children with positive results and provide or refer for a medical evaluation, chest x-ray, and any other laboratory studies needed for the diagnosis of TB disease.
- Report to the local health department any confirmed or suspected case of TB disease within one day of identification (California Code of Regulations, Title 17, Section 2500). Contact your local health department for specific instructions about reporting children with latent TB infection, or converters, and for additional information regarding therapy.
- If TB disease is not found, place children and adolescents with positive TST on therapy, unless medically contraindicated.
- Refer all household contacts of persons being treated for active TB disease to the local health department for follow-up or contact tracing.

*The complete list of screening requirements, Pediatric TB Risk Assessment Questionnaire, and considerations for referral, treatment and/or follow-up can be found at:

- www.dhcs.ca.gov/services/chdp/Documents/Letters/chdppin1104.pdf

Please visit our website to download our 2011 Preventive Health Guidelines (PHGs):

- www.molinahealthcare.com/medicaid/providers/ca/resource/Pages/guide_prevent.aspx

To request a hardcopy of the PHG, please contact our Provider Services at 888-665-4621.

[1]http://www.cdph.ca.gov/programs/tb/Documents/TBCB-WorldTBDay2010-combined.pdf
[2]American Academy of Pediatrics. Tuberculosis. In: Pickering LK, Baker CJ, Kimberlin DW, Long SS, eds. Red book: 2009 report of the Committee on Infectious Disease. 28th ed. Elk Grove Village, IL: American Academy of Pediatrics, 2009:680–701.
[3]http://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm

Recredentialing

Recredentialing process is based on the last credentialing or recredentialing approval date. As required by guidelines and accreditation bodies, all practitioners must be recredentialed at least every 36 months. Recredentialing is initiated six months prior to your recredentialing due date. All practitioners are expected to respond to the requests in a timely manner. Lack of timely return of the completed recredentialing application or failure to provide the necessary information may result in network termination and completion of the initial credentialing process again. Please complete your recredentialing information as soon as you receive it to ensure continued participation with Molina.

Helpful Credentialing & Recredentialing Tips:

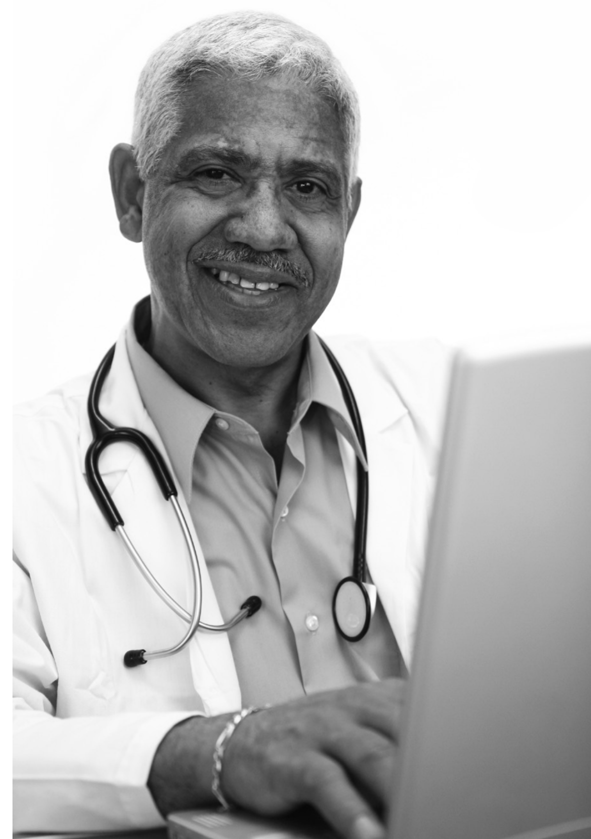
Upon receipt, the application will be reviewed for completeness. Your credentialing/recredentialing application should be submitted correctly and completely to be processed without delays. Practitioners and providers must respond in a timely manner to courtesy requests for missing information or additional credentialing information. To ensure that credentialing/recredentialing processes run timely and smoothly, please confirm that:

- All required information is timely submitted.
- All questions are answered.
- All information is current and required source documents are included, such as your proof of malpractice insurance, Federal Drug Enforcement Agency (DEA) certificate, Controlled Dangerous Substance (CDS) certificate, etc.
- When submitting insurance policies, make sure you send updated proof of professional liability.
- Information on your application matches the information on your source documents.
- Your attestation has not expired.

The Council for Affordable Quality Healthcare (CAQH) online Universal Provider Datasource® (UPD):

CAQH's universal credentialing data source is a web-based credentialing tool that streamlines the credentialing process by enabling you to complete your credentialing/recredentialing application online. There is no cost to physicians or other healthcare professionals to use UPD. This universal application database and information captured by CAQH is time efficient, comprehensive and in accordance with established industry standards. For more information, please visit the CAQH website at www.caqh.org

To help complete the recredentialing process in a timely manner and to ensure your network participation remains uninterrupted, we ask you to submit all current documents as outlined in your recredentialing notice. Thank you for your attention to Molina's credentialing and recredentialing processes and providing our members with quality healthcare.



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