



Welcome to the winter issue of Advantage, our newsletter for ArchCare Advantage network providers. This edition includes the latest updates on ArchCare Advantage HMO Special Needs Plan, as well as other important news and information to help you care for our members.

We welcome your questions and feedback. Please let us know what you think by dropping a note to Advantage Provider News, 33 Irving Place, 11th Floor, New York, NY 10003. Or email us at AAProviderServices@archcare.org.

As always, thank you for your continued dedication to ArchCare Advantage and our members.


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GLAUCOMA SCREENING IN OLDER ADULTS

Healthcare Effectiveness Data and Information Set (HEDIS) guidelines from the National Committee for Quality Assurance set quality standards for all Medicare members age 65 years and older in managed care plans. The 2013 HEDIS guideline "Glaucoma Screening in Older Adults" requires all ArchCare Advantage members to have a glaucoma examination by an eye care professional for early identification of glaucomatous conditions every two years. All members not diagnosed with glaucoma as identified by ICD-9 codes 365.1-365.9, 377.14, or 365.0 (glaucoma suspect), must have a glaucoma screening before December 31, 2014 if they have not undergone screening since January 1, 2013. The screening must be performed by an ophthalmologist or optometrist and the finding recorded in the medical record.

Codes that identify that a glaucoma screening eye exam has been done include: 92002, 92004, 92012, 92014, 92081-92083, 92100, 92120, 92130, 92140, 99202-99205, 99213-99215, 99242-99245.

ArchCare Advantage members previously diagnosed with glaucoma should continue to receive routine follow-up care from their eye care professional.

ABOUT GLAUCOMA

Following is a brief clinical overview of glaucoma in the elderly based on a review of Uptodate.com and the Merck Manual of Geriatrics.

Glaucoma is a silent disease that progressively damages the optic nerve and can lead to vision loss. It is the second most common cause of blindness in the United States, and the leading cause of blindness among blacks and Hispanics. Only an ophthalmologist or optometrist who performs comprehensive examinations of the eye, including measurement of intraocular pressure, funduscopy, and visual field testing can definitively diagnose glaucoma. Primary care providers should routinely examine



the fundus looking for "cupping," which is both sensitive and specific for glaucoma, and refer to the ophthalmologist or optometrist as appropriate. Glaucoma can occur at any age, but is six times more common among people over age 60 and often goes undiagnosed and untreated, leading to decreased vision, depression, loss of function, falls, and restricted movement from the home.

Risk factors for glaucoma include older age, positive family history, black race, thinner central corneal thickness, systemic hypertension, diabetes, and myopia. In blacks, glaucoma is more severe and often develops at an earlier age, making blindness six to eight times more likely.

Glaucoma may be categorized as open-angle or closed-angle. The most common type in the older population is open-angle glaucoma. About 98% of the aqueous humor that is normally produced in the eye exits through the angle or canal. In open-angle glaucoma, the intraocular pressure (IOP) *continued from page 1*

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GLAUCOMA SCREENING IN OLDER ADULTS

is elevated because outflow is inadequate despite an angle that appears unobstructed. This elevated IOP damages retinal nerve cells either by direct nerve compression or diminution of blood, leading to pressure on the optic nerve and patchy vision. Two-thirds of patients with glaucoma have elevated (> 21 mm Hg) IOP. In at least one-third of patients with glaucoma, IOP is within the average range but optic nerve damage and visual field loss typical of glaucoma are present. This is called normal or low-pressure glaucoma. IOP may be normal or high, but is almost always higher in the eye with greater optic nerve damage. Glaucoma occurring with average-range IOP is more common among people of Asian descent.

Individuals with open-angle glaucoma rarely experience symptoms. When vision loss does occur, it usually begins by affecting the edges of the patient's field of vision. While central vision is clear, things off to the side are not. This is known as "tunnel vision," and can lead to trips and falls, trouble reading, or difficulty driving. There is no loss of visual acuity as long as central vision is preserved. Central visual field loss is a late manifestation of open-angle glaucoma. As the disease gets worse, all vision can be affected. Visual field loss cannot be recovered once it has occurred.

Open-angle glaucoma is most often detected incidentally, during comprehensive ophthalmic examination by an eye care specialist. High elevations of intraocular pressure up to 40 mmHg in patients with open-angle glaucoma typically cause no pain, redness, or visual symptoms.

The mean progression rate from a full field of vision to blindness takes approximately 25 years in untreated patients, while the median progression rate is approximately 70 years, since only a small minority of patients progress rapidly to blindness. Because early symptoms are uncommon, the older patient becomes aware of visual field loss only when optic nerve atrophy is marked. Screening is essential, because treatment can prevent or slow the progression of vision loss but cannot reverse damage that has already been done.

The following types of examinations may be used to diagnose glaucoma:

FUNDUS EXAMINATION — The primary care clinician should be attentive to the presence of cupping seen in the fundus. Cupping describes a hollowed-out appearance of the optic nerve or "disc" on examination. A cup with a diameter greater than 50 percent of the vertical disc diameter is indicative of glaucoma.

Although cupping has the highest sensitivity and specificity of any other finding on eye examination, no single cutoff criterion yields sufficiently high sensitivity and specificity to make cupping a useful diagnostic test. Combining cupping with other diagnostic criteria increases diagnostic yield.

VISUAL FIELD TESTING — Open-angle glaucoma ideally should be diagnosed before there is significant visual field loss. However, confrontational field-testing using the examiner's fingers is not useful in the detection of glaucoma. Automated perimetry is an important and much more reliable diagnostic tool.

While automated perimetry has become the standard of care for optometric and ophthalmic practice in the detection and monitoring of glaucoma, there remains a role for careful manual perimetry in some cases. Reliable field-testing requires comprehension and cooperation on the part of the patient. Dementia and other mental or physical problems may preclude testing in certain individuals, forcing the

clinician to rely upon other variables in diagnostic and therapeutic decision-making.

INTRAOCULAR PRESSURE — Elevated intraocular pressure alone does not establish the diagnosis of open-angle glaucoma. One-third to one-half of all individuals with glaucoma field defects has intraocular pressures ≤ 21 mmHg when first detected (normal IOP = 8 to 21 mmHg). In addition, more than 90 percent of adults with pressures > 21 mmHg have no optic nerve damage. However, all patients with elevated IOP should be referred to an ophthalmologist given their higher risk of open-angle glaucoma.

The presence of either increased IOP (> 21 mmHg) or increased vertical cup/disc ratio (≥ 0.5) increased diagnostic sensitivity to 61 percent but decreased specificity to 84 percent. Ophthalmologists and optometrists can measure IOP by applanation tonometry, pneumotonometer, or air-puff tonometry. These methods require specialized equipment and skill, and thus fall out of the realm of the primary care clinician. Schiottz tonometry uses a handheld device that is relatively inexpensive, but requires frequent use for reliable results. Generalists who practice in populations that do not have access to optometric or ophthalmic care can learn Schiottz tonometry and use it in conjunction with optic disc examination in deciding whom to treat or refer.

Once diagnosed, glaucoma is treatable. Effective treatments for glaucoma all work by lowering the pressure inside the eye, and include eye drops, laser therapy and surgery.

Initial treatment almost always begins with eye drop medications, with the goal of achieving a target IOP 20 to 40 percent below pretreatment readings. The two main types of eye drops are prostaglandins and beta-blockers. Patients may require one or both.

Adherence to daily dosing, preferably with a medication that can be prescribed once daily, is critical to successfully controlling IOP. In general, the greater the damage that has already occurred, the more the IOP must be lowered to prevent further vision loss. If damage progresses, the IOP goal should be lowered further and additional therapy initiated.

Laser therapy is sometimes used to improve the way fluid drains from the eye. Surgery to make a small opening or insert a tiny tube in the eye to promote adequate drainage may also be necessary. Surgery is seldom needed, however, since most older patients are successfully treated with medication.

Since vision lost as a result of glaucoma cannot be recovered, screening by an ophthalmologist or optometrist is an important part of the ArchCare Advantage program.

IN SUMMARY:

- Primary open-angle glaucoma is usually related to elevated IOP but may occur with normal IOP
- Vision loss due to glaucoma cannot be recovered
- Diagnosis is made by evaluation with ophthalmoscopy, measurement of IOP and/or visual field testing
- Treatment typically begins with topical drugs instilled into the eye, with the aim of lowering IOP by 20 to 40 percent
- Surgery may be considered if drugs are not effective or visual loss is severe, but is seldom needed in the elderly

DRUG INTERACTIONS: REDUCING THE RISK

Drug-drug interactions (DDIs) are adverse reactions that occur when two or more drugs are taken at the same time. DDIs may increase or decrease drug effectiveness and escalate the risk of serious side effects. To help address the rising rate of the DDIs, ArchCare Advantage has developed a list of target and contraindicated drugs. Plan members who are identified as having filled prescriptions for drugs with the potential for drug-drug interactions have been assigned to our field staff for appropriate follow-up with the patient and prescriber. We have also implemented mandatory monthly medication reviews by our Nurse Practitioners/Care Managers to detect and prevent potentially hazardous medication combinations. ArchCare Advantage will continue to monitor drug-drug interaction rates and develop additional safeguards as necessary to ensure patient safety.

Please refer to the table below when reviewing the medication regimens of members under your care.

Target and Contraindicated Drugs - 2014

Category	Target Drug or Drug Class	Precipitant Drug or Drug Class
A	Benzodiazepines: alprazolam, midazolam, triazolam	Azole antifungal agents: ketoconazole, itraconazole, fluconazole, posaconazole, voriconazole
B	carbamazepine	propoxyphene
C	cyclosporine	Rifamycins: rifampin, rifabutin, rifapentine
D	digoxin	clarithromycin, erythromycin, azithromycin, telithromycin
E	Ergot alkaloids: ergotamine, dihydroergotamine	clarithromycin, erythromycin, telithromycin
F	Estrogen/progestin oral contraceptives: desogestrel-ethinyl estradiol, drospirenone-ethinyl estradiol, estradiol valerate-dienogest, ethinyl estradiol-ethynodiol, ethinyl estradiol levonorgestrel, ethinyl estradiol/norethindrone, ethinyl estradiol-norgestimate, ethinyl estradiol-norgestrel, mestranol	Rifamycins: rifampin, rifabutin, rifapentine
G	MAO inhibitors: isocarboxazid, linezolid, phenelzine, rasagiline, selegiline, tranylcypromine	Sympathomimetics: amphetamines, atomoxetine, benzphetamine, dextroamphetamine, diethylpropion, isometheptene, methamphetamine, methylphenidate, phendimetrazine, phentermine, phenylephrine, pseudoephedrine, tapentadol, dexmethylphenidate, lisdexamfetamine Serotonergic agents: buspirone, citalopram, cyclobenzaprine, desvenlafaxine, dextromethorphan, duloxetine, escitalopram, fluoxetine, fluvoxamine, meperidine, milnacipran, mirtazapine, paroxetine, sertraline, sibutramine, tetrabenazine, tramadol, trazodone, venlafaxine
H	methotrexate	trimethoprim/sulfamethoxazole
I	Nitrates: amyl nitrite, isosorbide dinitrate, isosorbide mononitrate, nitroglycerin	Phosphodiesterase inhibitors: sildenafil, tadalafil, vardenafil
J	simvastatin (40mg & 80mg)	amiodarone
K	tamoxifen	bupropion, duloxetine, fluoxetine, paroxetine
L	theophylline	ciprofloxacin, fluvoxamine
M	mercaptopurine	allopurinol
N	warfarin	cimetidine, trimethoprim/sulfamethoxazole Fibrates: fenofibrate, fenofibric acid, gemfibrozil NSAIDs: diclofenac, etodolac, fenoprofen, flurbiprofen, ibuprofen, indomethacin, ketoprofen, ketorolac, meclofenamate, mefenamic acid, meloxicam, nambumetone, naproxen, oxaprozin, piroxicam, sulindac, tolmetin

CLAIMS CORNER



BILLING AND REIMBURSEMENT

Claims submission errors usually result in unprocessable and rejected claims. To reduce claim denials and administrative costs, be sure to submit all claims completely and correctly the first time, with all required data elements.

DIAGNOSIS CODES

Coding guidelines dictate that ICD-9-CM diagnoses be coded to the highest degree of accuracy and specificity. This means assigning the ICD-9-CM code that most fully explains the narrative description of the patient's symptom or diagnosis.

Use of ICD-9-CM diagnosis codes that are not valid and current, or the use of "miscellaneous" codes, e.g., 799.9, will result in denial of the claim.

OVERLAPPING SERVICE MONTHS

To avoid delays or processing errors, providers are required to submit a separate claim form for services incurred in different months.

REMITTANCE ADVICE MESSAGES

Review your remittance advices in a timely manner for messages about claim rejections. In some instances, there may be more than one message explaining why the claim was rejected. Corrected claims should be submitted as soon as possible to avoid further delay in payment or the possibility of rejection for untimely resubmission.

ENCOUNTER DATA SUBMISSION REMINDER

Skilled nursing facility and home health encounters must submit HIPPS codes if available. Effective with dates of service on or after July 1, 2014, providers will be required to submit HIPPS codes in the UB-04 or 837 Institutional formats. Encounters submitted without the appropriate HIPPS codes will be rejected.

If you have questions regarding your contract and billing obligations, contact your provider service representative to review the terms of your agreement with ArchCare, your rates, and billing requirements.

BALANCE BILLING AND COORDINATION OF BENEFITS

Providers must not balance-bill members, and should bill only for applicable co-payments, deductibles or coinsurance. Contracted providers agree to accept the ArchCare Advantage contracted rate as payment in full, and not seek additional payment from members for covered benefits shown in the Evidence of Coverage, even in the event of non-payment by ArchCare Advantage. For members that have both Medicare and Medicaid, providers are expected to coordinate the benefits by billing Medicaid as the secondary payer. Providers should help educate members about coordination of their Medicare and Medicaid benefits to ensure that they are receiving all the benefits they are entitled to.

COMPLIANCE CORNER

PREVENTING PROVIDER MEDICAL IDENTITY THEFT

Physicians and other providers as well as Medicare and Medicaid beneficiaries are all at risk for medical identity theft. Medical identity theft is "the appropriation or misuse of a patient's or provider's unique medical identifying information to obtain or bill public or private payers for fraudulent medical goods or services," according to Shantanu Agrawal, MD, and Peter Budetti, MD, JD, in their article "Physician Medical Identity Theft" in the February 1, 2012 issue of the *Journal of the American Medical Association*.

The Centers for Medicare and Medicaid Services (CMS) is working to raise awareness of this issue among healthcare providers and help them protect their medical identities.

COMMON PROVIDER IDENTITY THEFT SCHEMES

A common provider medical identity theft scheme involves the billing of services in a physician's or other provider's name for services that were never provided. Another common scheme involves the use of physician and other provider medical identifiers such as NPI and tax ID numbers to refer patients for additional services or products, such as home health services, diagnostic testing or medical equipment and supplies.

PROVIDER RISKS

The primary risk factor for medical identity theft is provider complicity in fraud schemes. Providers who voluntarily permit misuse of their identifiers are at significantly higher risk of subsequent identity theft. Providers permit the misuse of their medical identifiers when they:

- Sign referrals for patients they do not know or sign blank referral forms;
- Sign Certificates of Medical Necessity (CMNs) for patients who do not need the service or supply;
- Sign CMNs even when documentation disputes medical need; or,
- Sign CMNs for more services or greater quantities of supplies than patients actually need.

Purposeful misuse of medical identifiers can lead to significant consequences, including civil monetary penalties, criminal fines and restitution, prison time, and exclusion from the Medicare and Medicaid programs. Physicians and other providers can be held liable for these actions even without evidence of other fraud.

REPORT IT

Please do your part to prevent fraud by reporting suspected medical identity theft to your local law enforcement agency, your state Medicaid agency, or your regional office of the U.S. Department of Health and Human Services. You can also report suspected fraud to ArchCare's Compliance Hotline at 800-443-0463, or to ComplianceReport@archcare.org.