

THE INSIDE STORY



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Rapid Flu Test, CPT Code 87804

Scott & White Health Plan (SWHP) only covers the Rapid Flu Test, CPT code 87804, for children ages 0 through 5 and SeniorCare members in accordance with the member's contracted benefits.

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SCOTT & WHITE

Drug Information Center
Department of Pharmacy
Monday, Jun. 13, 2011

High-dose simvastatin
Rx Statgram
Safety label changes

Safety Label Changes

Recently, a review of clinical trial data and submitted adverse event reports prompted the Food and Drug Administration (FDA) to modify the label information for simvastatin and simvastatin-containing medications (Zocor®, Vytorin®, Simcor®). All data showed that patients taking simvastatin 80 mg had an increased risk of muscle injury compared to patients taking lower doses or other statin drugs. The risk of injury is highly associated with: use of 80 mg of simvastatin within the first year of treatment, drug-drug interactions with certain medications, and a genetic predisposition for simvastatin-related muscle injury.

FDA Recommendations

At this time, the FDA recommends the following:

- **Simvastatin 80 mg be used only in patients who have been taking the dose for 12 months or more and have not experienced any muscle toxicity and should NOT be prescribed to new patients**
- **Patients who are unable to adequately lower their level of LDL-C on simvastatin 40 mg should NOT be given the higher 80 mg dose; instead, they should be placed on an alternative LDL-C lowering treatment(s)**
- **Simvastatin should not be used with certain medications which can raise the level of simvastatin in the body and increase the risk of myopathy (see table below)**

Old vs. New Contraindications and Dose Limitations

Previous Label	New Label*
Avoid simvastatin with: Itraconazole (Sporanox®) Telithromycin (Ketek®) Ketoconazole (Nizoral®) HIV protease inhibitors Erythromycin (EryTab®) Nefazodone (Serzone®) Clarithromycin (Biaxin®)	Contraindicated with simvastatin: Itraconazole (Sporanox®) Telithromycin (Ketek®) Ketoconazole (Nizoral®) HIV protease inhibitors Posaconazole (Noxafil®) Erythromycin (Ery-Tab®) Gemfibrozil (Lopid®) Clarithromycin (Biaxin®) Danazol (Danocrine®) Cyclosporine(Sandimmune®/Neoral®/Gengraf®)
Do not exceed 10 mg simvastatin daily with: Gemfibrozil (Lopid®) Cyclosporine (Sandimmune®/Neoral®/Gengraf®) Danazol (Danocrine®)	Do not exceed 10 mg simvastatin daily with: Amiodarone (Cordarone®/Pacerone®) Verapamil (Calan®/Isoptin®) Diltiazem (Cardizem®)
Do not exceed 20 mg simvastatin daily with: Amiodarone (Cordarone®/Pacerone®) Verapamil (Calan®/Isoptin®)	Do not exceed 20 mg simvastatin daily with: Amlodipine (Norvasc®) Ranolazine (Ranexa®)
Do not exceed 40 mg simvastatin daily with: Diltiazem (Cardizem®)	
Avoid large quantities of grapefruit juice (> 1 quart daily)	Avoid large quantities of grapefruit juice (> 1 quart daily)

*Changes are highlighted in yellow

For more information, please visit the [FDA website](#).

1. Food and Drug Administration. FDA announces new safety recommendations for high-dose simvastatin. (Press Announcement 8 June 2011). Available at: <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm258338.htm> Last updated: 6/8/11.



Scott & White Health Plan (SWHP) has previously distributed written copies of SWHP formulary documents. In an effort to ensure our providers have current and timely formulary information, SWHP will no longer be distributing written copies. For the most up-to-date SWHP formulary information (pharmaceutical management procedures), SWHP encourages providers to visit our web site.

SWHP formulary information can be found on the following web sites:

- Go to www.swhp.org under the Providers tab and click on Drug Formulary.
- For providers with access to **S&W InSite**, go to the Physician Resources tab and click on Pharmaceutical Resources.
- The following formulary documents are available on the above web sites:
 - SWHP alphabetical formulary
 - SWHP therapeutic category formulary
 - SWHP Specialty formulary
 - SWHP SeniorCare Rx formularies
- Information regarding monthly formulary updates and availability of new generics will also be posted.

If you have any questions or wish to obtain a printed copy of the SWHP formularies or pharmaceutical management procedures, please contact Scott & White Prescription Services at (800) 728-7947.

Medical Director's Corner



Dr. Marylou Buyse, Chief Medical Director, SWHP

FRIDAY FOCUS: A Tribute to Craig Clanton, MD

We are dedicating this issue of Friday Focus to our good friend and trusted colleague Dr. Craig Clanton. We all love Craig and miss his talent, intellect, passion, and humor. He was a skilled physician, educator, and administrator who gave his all to everything he did, even in the last few months preceding his death. Craig spent 25 years in total at Scott and White with the last 14 years of his career as a Medical Director for the Scott and White Health Plan. He was instrumental in the plan's growth, network expansion, and success in physician collaboration.

We are humbled and honored to carry on in our roles as Scott and White Health Plan Medical Directors in what is surely a "tough act to follow." Although Dr. Beki Preston played a large role with Craig over the past 5 years, the rest of us began our work with the health plan during the last two years. Craig and Beki have taught us a lot.

We all know that as an enterprise, we must continue to evolve, innovate, and deliver greater value in the years to come. Please realize that our goal is to support your ability to deliver the most effective, highest quality, patient focused care available within the constraints of reasonable fiduciary responsibility. We answer to you as providers of care, your patients as recipients of care, and your patients and their employers as the purchasers of care. Unfortunately, the link between care and what it costs is often distorted, avoided, and not adequately owned.

Our pledge to you in the coming years is to listen, use data to better understand our population and how we deliver care, and based on insights from that information, work with you to develop more effective and satisfying systems of care. We can help you approach and coordinate your efforts from a population based vs. individual patient perspective. As an example, we have funded Vitality Coordinator nurse positions in five of our larger primary care clinics to help boost quality performance results. We have interest and expertise in evidence based coverage policy, practice variation, care coordination, and patient engagement and support. Our intent is to utilize these tools to streamline and simplify our processes to better aide you and your patients in the realization of better outcomes and a better experience.

Please let us know how we can better serve our members, your patients, their employers, and you. Even though we may at times appear to be an obstruction, we recognize that the real work happens at the patient-doctor relationship level. However, a key part of our job is to assure that the work occurs at a reasonable cost; which though sometimes painful, benefits all of us and those we serve. We look forward to our future with you, and do so in tribute to Craig and his legacy. Thank you for remembering him with us, and thank you for what you do, day in and day out to serve our members, your patients. We serve a noble purpose and Dr. Craig Clanton was a noble man and physician.

Respectfully,

Mike Averitt MD, Marylou Buyse MD, Beverly Grimshaw MD, Randall Grimshaw MD, David Krauss MD, Beki Preston MD, and Scott Simpson MD

FRIDAY FOCUS: The Dialog Center - helps your patients find the information they need!!!

Wouldn't you love to have a SW branded, medical information site with education you can trust?

SWHP introduces the Dialog Center. Share this with your patients.

How does one LOG ON to learn more about this site?

Go to the SWHP website members section. <http://www.swhp.org/members>

Now click on Dialog center (in green) just below the picture.

If this is your first visit to the site, you will need to register ("register now" in blue). Your member ID number is on your SWHP insurance card listed as Contract No. BUT you must add 00 after the contract number to make an 11 digit code. If you are unsure of your member ID number/contract number, call SWHP at 1800.321.7947 for assistance.

Upon entering the site you will see many options. The tabs above the welcome sign show Health Information or Health Coach. Health Information has multiple tools to assist with patient education. Or send a message via Health Coach tab to receive personalized assistance with several medical conditions.

As always, your ideas and feedback are appreciated.

Thanks for reading and for the quality work you do. All Friday Focus editions may be found at the SWHP website: <http://www.swhp.org/homepage/providers/fridayfocus>.



Beverly Grimshaw, MD
Scott & White Health Plan Medical Director

FRIDAY FOCUS: All Cause Readmissions

This is the first year for this HEDIS® measure which will look at all cause readmissions.

The denominator for this measure is based on discharges, not members; and includes any acute inpatient discharge between January 1 and December 1 of 2011 for members 18 to 89 years of age. It does not include discharges for maternity stays; or for discharge reason of death or leaving AMA (Against Medical Advice).

Any patient who is readmitted within 30 days of their initial discharge date will be counted in the numerator as a readmission.

Discharge from a hospital is a critical transition point in a patient's care. Nationwide, readmission rates during the first month post hospitalization are about 20%. Although different facilities have different definitions of preventable readmissions, most estimate that ¼ to ½ of readmissions are avertable. Initiatives to improve communication with patients and their caregivers and to coordinate care after discharge may help lower readmission rates. While not all preventable readmissions can be avoided, some may be averted with the best quality of care rendered in the hospital, and assistance with a smooth transition to outpatient care follow up. This measure is intended to lower preventable readmissions, thereby demonstrating NCQA's goal of improving national health care.

For more information on NCQA and HEDIS® see <http://www.ncqa.org>. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

As always, your ideas and feedback are appreciated.

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Beverly Grimshaw, MD

Scott & White Health Plan Medical Director

FRIDAY FOCUS: Screening Mammography

Screening mammography is recommended by numerous quality and healthcare organizations and therefore it should be no surprise that it is a HEDIS® measure as well. The HEDIS® methodology looks for a mammogram at least every two years on women 40-69 years of age. The exclusion is a history of bilateral mastectomy. Last year, the SWHP scored in the 25th percentile on this measure with our goal being the 90th percentile.

The American Cancer Society recommends yearly screening mammography for all women beginning at age 40. ACOG recommends mammography every 1-2 years for women in their 40's, and every year after age 50. The USPSTF recommends yearly screening after age 50.

The SWHP encourages women to discuss the benefits and risks of yearly mammography with their doctors and offers coverage of yearly screening mammograms starting at age 40. This coverage, as with other preventive services, is offered with no cost share for most members.

Thank you for taking the time to read this and for all the quality work you do. All Friday Focus editions are available on our SWHP website: <http://www.swhp.org/homepage/providers/fridayfocus>.



Beverly Grimshaw, MD
Scott & White Health Plan Medical Director

FRIDAY FOCUS: Clinician Feedback Tool

Given the increasing focus on clinical quality and cost effectiveness, we would like to pilot a Clinician Feedback Tool developed by Thomson-Reuters, one of our data partners. We will begin by sharing this information with Family Practice and Internal Medicine physicians. The tool uses our claims information to build clinician specific reports regarding compliance with nationally recognized quality metrics and risk adjusted cost of care compared to local same practice peers. Each report spans a rolling 12 month window and is produced in a summary format (with patient, diagnostic, place of treatment, and utilization specific detailed data available).

Individual patients are attributed by diagnostic episodes to an individual physician (NP, PA) based upon the preponderance of outpatient E&M services delivered vs. by panel assignment. Cost includes payment for all services received by the patient, across all providers and facilities, for a given episode. 19 quality measures, adopted from the National Quality Forum, make up the quality component of the report. The measures are similar to, but less specific than HEDIS® measures.

The summary report provides each physician with an aggregate clinical effectiveness (quality) and cost efficiency score. This data is displayed in graphic format vs. one's peers and another table lists all individual quality metric completion percentages. Our intent is to provide this information to you as a proxy for practice variation so that you might better appreciate your own performance from a population based perspective. Although we realize that claims data has certain limitations and that factors beyond your direct control can influence your scores; we hope you will consider your report as you reflect and plan for ongoing practice improvement efforts.

We will begin mailing reports to all Family Practice and Internal Medicine physicians, with 50 or more attributable patients, later this month. If you do not receive a feedback report, it is most likely you did not see enough eligible health plan patients. We welcome your questions, comments, and critique as we work to bring you information we hope you can use (clinicianfeedback@swmail.sw.org). We would also be happy to produce more detailed versions of your report and/or discuss your report on request. Thank you very much for taking the time to review your report and for the care you provide every day.



Scott Simpson, MD
Scott & White Health Plan Medical Director

FRIDAY FOCUS: Shared Decision Making® Can Save You Time

What is Shared Decision Making®? This is a new program offered by SWHP that contains non biased information about different treatment options for the same condition. Topics range from joint surgery to prostate conditions to bariatric surgery and many more. The patients will receive evidence based medical information discussing various treatment options including the risks and benefits of each type. This encourages a more informed patient and decreases the amount of time the doctor spends explaining each option.

The doctor or the patient can access Shared Decision Making® via the Dialog Center at www.swhp.org/members, or by calling 877-505-7947 any time, day or night. Press 1 to be connected to a health coach who will begin the education. The patient may select a male or female coach. Following the initial discussion, the coach will then mail a brochure and DVD to the patient for their review prior to the next conversation. The DVD includes experiences of real patients who have faced similar decisions.

An informed patient is a happier patient, and one with realistic expectations. A coached patient will be able to ask directed questions and understands the risks inherent in each treatment. This allows the doctor to spend more time discussing the preferred option with the patient, rather than reviewing all the potential treatment choices.

As always, your ideas and feedback are appreciated.

Thanks for reading and for the quality work you do. All Friday Focus editions may be found at the SWHP website: <http://www.swhp.org/homepage/providers/fridayfocus>.

SWHP Network Providers and Administrative Staff

As a reminder, we encourage you to refer to the online Provider Manual for updates to payment policies, quality improvement programs, medical policies and general health plan information. In addition, SWHP generally applies CMS rules and regulations with regards to claim edits and payment policies. We ask that you routinely visit our website for more information as updates may occur throughout the year.



Beverly Grimshaw, MD
Scott & White Health Plan Medical Director

FRIDAY FOCUS: Clinical scenarios involving the 24 hour radiology line 254-724-1728.

This is a recounting of two actual clinical situations using the radiology line. The names have been changed to protect everyone.

#1. Patient presents to the hospital with a severe headache he developed while bench-pressing at school. He is on the heavy weight lifting team. It lasts for several minutes after the weight lifting and it has now occurred on 3 different occasions. Dr. Emmett Mergency plans a lumbar puncture to rule out subarachnoid hematoma, but wonders about the best imaging for the patient. He calls Dr. Xavier Ray on the 24 hour radiology line at 254-724-1728.

“Dr X. Ray, this is Dr. E. Mergency. I have a patient with a severe valsalva related headache. I wonder if I should do a head CT with and without contrast?”

“While that would be acceptable, you may not need the added radiation exposure of doing both. I think if your CT without contrast is clear, you can proceed with your LP. Also, you might consider an outpatient MRA in the future for better delineation of the vasculature in the brain and to rule out a small aneurysm.”

#2. Patient has mediastinal nodules. Should we proceed with a CT guided biopsy or would a PET scan be indicated first? Dr. X. Ray states that while a CT guided biopsy is useful for tissue diagnosis, getting the PET scan first would help us know which nodules to biopsy. That way we would be getting a more specific biopsy of the problematic nodes, rather than just a blind biopsy.

When you call to speak to a radiologist at **254-724-1728**, you may not get Dr. Xavier Ray. However, all of the radiologists are helpful and friendly and appreciate the chance to help us in our clinical dilemmas. You can call this number for assistance in selecting an imaging study, help with understanding a radiology report or help in determining risk for radiation exposure in a patient with multiple previous studies. As always, your ideas and feedback are appreciated.

Thanks for reading and for the quality work you do. All Friday Focus editions may be found at the SWHP website: <http://www.swhp.org/homepage/providers/fridayfocus>



Beverly Grimshaw, MD
Scott & White Health Plan Medical Director

FRIDAY FOCUS: Health Education Audio Reference (HEAR) Library

This is a telephonic educational tool offered by SWHP for patient education on many health topics. HEAR contains over 300 English language topics, and 25 Spanish language topics.

Call 877-505-7947 and press 2. Listen to a list of topics and select the one that interests you. Or go to swhp.org and click on the bottom right teal tab, VitalCare Programs. At the bottom of the next page, you will find a link to list of topics for the HEAR library.

Some examples:

1831 Dietary Guidelines for Americans-2005
2251 Healthy Aging
1837 Healthy Eating for Children
1853 Healthy Snacks

After connecting to HEAR library, enter the 4 digit number of your selected topic.

SWHP continues to bring you healthier living through VitalCare tools, including HEAR, Shared Decision Making®, health coaches and condition guidance. All tools are also available through the www.swhp.org (<http://www.swhp.org/>) site, or 877-505-7947.

As always, your ideas and feedback are appreciated.

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Beverly Grimshaw, MD
Scott & White Health Plan Medical Director

FRIDAY FOCUS: The Alphabet Soup of Coding: CPT (Current Procedural Terminology), E/M (Evaluation and Management) and ICD-9 (International Classification of Diseases 9th edition)

Medical record documentation is critical for quality patient care, and required for accurate and timely reimbursement. Accurate and appropriate coding choices that correlate to the documentation will improve timely reimbursement. Payers may require documentation to validate the level of service provided and the necessity of the service.

The Evaluation and Management Service Guide by Centers for Medicare and Medicaid Services covers requirements and recommendations for appropriate coding.

See http://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf.

Selection of the correct CPT (including E/M) code and the correct diagnostic code is ultimately the responsibility of the billing physician. While the physician may delegate this responsibility to a professional coder, the physician is still responsible for accuracy and veracity of the claim. Therefore, in many offices, the physician prefers to select the appropriate coding choices.

National benchmarks are helpful in determining what an appropriate distribution of E/M levels might be. (Raw data available at: http://www.cms.hhs.gov/MedicareFeeforSvcPartsAB/04_MedicareUtilizationforPartB.asp.) In 2005 CMS reported the percent of each level of E/M code reported by family physicians. As expected, the results fell into a bell shaped curve. The lowest level, 99211 was 4%, 99212 was 8%, 99213 at 58%, 99214 at 28%, and the highest level, 99215 was 2%. (2002 distribution for comparison- 99211 - 5%, 99212 - 15%, 99213 - 60%, 99214 - 15%, and 99215 - 5%.) Reports did not comment on the accuracy of these codes. Variations from norm may trigger a health plan audit. Coding is critical since the health plan has to base its information on the coding reports we receive from providers.

On the horizon, ICD-10 will be required for all services provided beginning October 1, 2013, for all HIPAA covered groups. This will not affect the use of CPT coding. Look for a future Friday Focus edition about ICD-10 comparison to ICD-9.

SWHP continues to bring you healthier living through VitalCare tools, including HEAR, Shared Decision Making®, health coaches and condition guidance. All tools are also available through the www.swhp.org site, or 877-505-7947.

As always, your ideas and feedback are appreciated.

Thanks for reading and for the quality work you do. All Friday Focus editions may be found at the SWHP website: <http://www.swhp.org/homepage/providers/fridayfocus>.



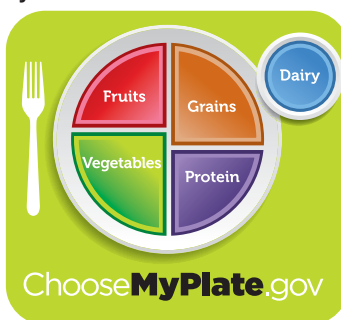
Beverly Grimshaw, MD
Scott & White Health Plan Medical Director

FRIDAY FOCUS: Healthy Eating

Q: How do you change a circle ○ to a pyramid ▲ and then back to a circle ○ ?

A: Ask the USDA. And check out their new dietary guidelines called “My Plate.”

In the 1940’s USDA developed “A Guide to Good Eating” with 7 basic food groups and a circular pattern. This evolved over several years until 1992 when the concept of the food pyramid was introduced. My Plate was introduced this year, along with an updating of USDA food patterns for the *2010 Dietary Guidelines for Americans*. My Plate is divided into 4 unequal quadrants for fruits (red), vegetables (green), grains (brown) and proteins (purple). Dairy is blue circle where a drink would normally sit.



All physicians and many Americans in general, are concerned with the continued increasing obesity in our country. (see <http://www.swhp.org/sites/default/files/TeenObesity.pdf> for previous FF on this topic.) My Plate is expected to be a helpful visual cue replicating a normal place setting. The lower complexity than previous images is intended to make it accessible and useful for many groups of patients.

Some important messages from the USDA include:

- o Enjoy your food, but eat less.
- o Avoid oversized portions.
- o Make half your plate fruits and vegetables.
- o Switch to fat-free or low-fat (1%) milk.
- o Make at least half your grains whole grains.
- o Compare sodium in foods like soup, bread, and frozen meals—and choose foods with lower numbers.
- o Drink water instead of sugary drinks.

The website, <http://www.choosemyplate.gov/>, gives these tips, views of the image, and even interactive tools for your patients to learn more about healthy and appropriate eating patterns.

As always, your ideas and feedback are appreciated. Thanks for reading and for the quality work you do.

All Friday Focus editions may be found at the SWHP website:

<http://www.swhp.org/homepage/providers/fridayfocus>.



Beverly Grimshaw, MD

Scott & White Health Plan Medical Director

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2011

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B ¹		HepB	HepB			HepB						
Rotavirus ²			RV	RV	RV ²							
Diphtheria, Tetanus, Pertussis ³			DTaP	DTaP	DTaP	see footnote ⁹	DTaP					DTaP
<i>Haemophilus influenzae</i> type b ⁴			Hib	Hib	Hib ⁴		Hib					
Pneumococcal ⁵			PCV	PCV	PCV		PCV				PPSV	
Inactivated Poliovirus ⁶			IPV	IPV		IPV						IPV
Influenza ⁷						Influenza (Yearly)						
Measles, Mumps, Rubella ⁸							MMR		see footnote ⁸			MMR
Varicella ⁹							Varicella		see footnote ⁹			Varicella
Hepatitis A ¹⁰							HepA (2 doses)				HepA Series	
Meningococcal ¹¹											MCV4	

Range of recommended ages for all children

Range of recommended ages for certain high-risk groups

This schedule includes recommendations in effect as of December 21, 2010. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

- Hepatitis B vaccine (HepB).** (Minimum age: birth)
 - At birth:**
 - Administer monovalent HepB to all newborns before hospital discharge.
 - If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
 - If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (no later than age 1 week).
 - Doses following the birth dose:**
 - The second dose should be administered at age 1 or 2 months. Monovalent HepB should be used for doses administered before age 6 weeks.
 - Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).
 - Administration of 4 doses of HepB to infants is permissible when a combination vaccine containing HepB is administered after the birth dose.
 - Infants who did not receive a birth dose should receive 3 doses of HepB on a schedule of 0, 1, and 6 months.
 - The final (3rd or 4th) dose in the HepB series should be administered no earlier than age 24 weeks.
- Rotavirus vaccine (RV).** (Minimum age: 6 weeks)
 - Administer the first dose at age 6 through 14 weeks (maximum age: 14 weeks 6 days). Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
 - The maximum age for the final dose in the series is 8 months 0 days
 - If Rotarix is administered at ages 2 and 4 months, a dose at 6 months is not indicated.
- Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).** (Minimum age: 6 weeks)
 - The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
- Haemophilus influenzae* type b conjugate vaccine (Hib).** (Minimum age: 6 weeks)
 - If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
 - Hiberix should not be used for doses at ages 2, 4, or 6 months for the primary series but can be used as the final dose in children aged 12 months through 4 years.
- Pneumococcal vaccine.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])
 - PCV is recommended for all children aged younger than 5 years. Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
 - A PCV series begun with 7-valent PCV (PCV7) should be completed with 13-valent PCV (PCV13).
 - A single supplemental dose of PCV13 is recommended for all children aged 14 through 59 months who have received an age-appropriate series of PCV7.
 - A single supplemental dose of PCV13 is recommended for all children aged 60 through 71 months with underlying medical conditions who have received an age-appropriate series of PCV7.
- The supplemental dose of PCV13 should be administered at least 8 weeks after the previous dose of PCV7. See MMWR 2010;59(No. RR-11).**
- Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant.**
- Inactivated poliovirus vaccine (IPV).** (Minimum age: 6 weeks)
 - If 4 or more doses are administered prior to age 4 years an additional dose should be administered at age 4 through 6 years.
 - The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
- Influenza vaccine (seasonal).** (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])
 - For healthy children aged 2 years and older (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used, except LAIV should not be given to children aged 2 through 4 years who have had wheezing in the past 12 months.
 - Administer 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
 - Children aged 6 months through 8 years who received no doses of monovalent 2009 H1N1 vaccine should receive 2 doses of 2010–2011 seasonal influenza vaccine. See MMWR 2010;59(No. RR-8):33–34.
- Measles, mumps, and rubella vaccine (MMR).** (Minimum age: 12 months)
 - The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
- Varicella vaccine.** (Minimum age: 12 months)
 - The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
 - For children aged 12 months through 12 years the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
- Hepatitis A vaccine (HepA).** (Minimum age: 12 months)
 - Administer 2 doses at least 6 months apart.
 - HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.
- Meningococcal conjugate vaccine, quadrivalent (MCV4).** (Minimum age: 2 years)
 - Administer 2 doses of MCV4 at least 8 weeks apart to children aged 2 through 10 years with persistent complement component deficiency and anatomic or functional asplenia, and 1 dose every 5 years thereafter.
 - Persons with human immunodeficiency virus (HIV) infection who are vaccinated with MCV4 should receive 2 doses at least 8 weeks apart.
 - Administer 1 dose of MCV4 to children aged 2 through 10 years who travel to countries with highly endemic or epidemic disease and during outbreaks caused by a vaccine serogroup.
 - Administer MCV4 to children at continued risk for meningococcal disease who were previously vaccinated with MCV4 or meningococcal polysaccharide vaccine after 3 years if the first dose was administered at age 2 through 6 years.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/recs/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

Department of Health and Human Services • Centers for Disease Control and Prevention

Recommended Immunization Schedule for Persons Aged 7 Through 18 Years—United States • 2011

For those who fall behind or start late, see the schedule below and the catch-up schedule

Vaccine ▼	Age ►	7–10 years	11–12 years	13–18 years	
Tetanus, Diphtheria, Pertussis ¹			Tdap	Tdap	Range of recommended ages for all children
Human Papillomavirus ²	see footnote ²		HPV (3 doses)(females)	HPV series	
Meningococcal ³		MCV4	MCV4	MCV4	Range of recommended ages for catch-up immunization
Influenza ⁴		Influenza (Yearly)			
Pneumococcal ⁵		Pneumococcal			Range of recommended ages for certain high-risk groups
Hepatitis A ⁶		HepA Series			
Hepatitis B ⁷		Hep B Series			
Inactivated Poliovirus ⁸		IPV Series			
Measles, Mumps, Rubella ⁹		MMR Series			
Varicella ¹⁰		Varicella Series			

This schedule includes recommendations in effect as of December 21, 2010. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at <http://www.vaers.hhs.gov> or by telephone, **800-822-7967**.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).

(Minimum age: 10 years for Boostrix and 11 years for Adacel)

- Persons aged 11 through 18 years who have not received Tdap should receive a dose followed by Td booster doses every 10 years thereafter.
- Persons aged 7 through 10 years who are not fully immunized against pertussis (including those never vaccinated or with unknown pertussis vaccination status) should receive a single dose of Tdap. Refer to the catch-up schedule if additional doses of tetanus and diphtheria toxoid-containing vaccine are needed.
- Tdap can be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.

2. Human papillomavirus vaccine (HPV). (Minimum age: 9 years)

- Quadrivalent HPV vaccine (HPV4) or bivalent HPV vaccine (HPV2) is recommended for the prevention of cervical precancers and cancers in females.
- HPV4 is recommended for prevention of cervical precancers, cancers, and genital warts in females.
- HPV4 may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of genital warts.
- Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).

3. Meningococcal conjugate vaccine, quadrivalent (MCV4). (Minimum age: 2 years)

- Administer MCV4 at age 11 through 12 years with a booster dose at age 16 years.
- Administer 1 dose at age 13 through 18 years if not previously vaccinated.
- Persons who received their first dose at age 13 through 15 years should receive a booster dose at age 16 through 18 years.
- Administer 1 dose to previously unvaccinated college freshmen living in a dormitory.
- Administer 2 doses at least 8 weeks apart to children aged 2 through 10 years with persistent complement component deficiency and anatomic or functional asplenia, and 1 dose every 5 years thereafter.
- Persons with HIV infection who are vaccinated with MCV4 should receive 2 doses at least 8 weeks apart.
- Administer 1 dose of MCV4 to children aged 2 through 10 years who travel to countries with highly endemic or epidemic disease and during outbreaks caused by a vaccine serogroup.
- Administer MCV4 to children at continued risk for meningococcal disease who were previously vaccinated with MCV4 or meningococcal polysaccharide vaccine after 3 years (if first dose administered at age 2 through 6 years) or after 5 years (if first dose administered at age 7 years or older).

4. Influenza vaccine (seasonal).

- For healthy nonpregnant persons aged 7 through 18 years (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used.
- Administer 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza vaccine for the first

time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.

- Children 6 months through 8 years of age who received no doses of monovalent 2009 H1N1 vaccine should receive 2 doses of 2010-2011 seasonal influenza vaccine. See *MMWR* 2010;59(No. RR-8):33-34.

5. Pneumococcal vaccines.

- A single dose of 13-valent pneumococcal conjugate vaccine (PCV13) may be administered to children aged 6 through 18 years who have functional or anatomic asplenia, HIV infection or other immunocompromising condition, cochlear implant or CSF leak. See *MMWR* 2010;59(No. RR-11).
- The dose of PCV13 should be administered at least 8 weeks after the previous dose of PCV7.
- Administer pneumococcal polysaccharide vaccine at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition.

6. Hepatitis A vaccine (HepA).

- Administer 2 doses at least 6 months apart.
- HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, or who are at increased risk for infection, or for whom immunity against hepatitis A is desired.

7. Hepatitis B vaccine (HepB).

- Administer the 3-dose series to those not previously vaccinated. For those with incomplete vaccination, follow the catch-up schedule.
- A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.

8. Inactivated poliovirus vaccine (IPV).

- The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR).

- The minimum interval between the 2 doses of MMR is 4 weeks.

10. Varicella vaccine.

- For persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007;56[No. RR-4]), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
- For persons aged 7 through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
- For persons aged 13 years and older, the minimum interval between doses is 4 weeks.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/recs/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).
Department of Health and Human Services • Centers for Disease Control and Prevention

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age

PERSONS AGED 4 MONTHS THROUGH 6 YEARS					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Hepatitis B ¹	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Rotavirus ²	6 wks	4 weeks	4 weeks ²		
Diphtheria, Tetanus, Pertussis ³	6 wks	4 weeks	4 weeks	6 months	6 months ³
<i>Haemophilus influenzae</i> type b ⁴	6 wks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose) if first dose administered at age 12–14 months No further doses needed if first dose administered at age 15 months or older	4 weeks ⁴ if current age is younger than 12 months 8 weeks (as final dose) ⁴ if current age is 12 months or older and first dose administered at younger than age 12 months and second dose administered at younger than 15 months No further doses needed if previous dose administered at age 15 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months	
Pneumococcal ⁵	6 wks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose for healthy children) if first dose administered at age 12 months or older or current age 24 through 59 months No further doses needed for healthy children if first dose administered at age 24 months or older	4 weeks if current age is younger than 12 months 8 weeks (as final dose for healthy children) if current age is 12 months or older No further doses needed for healthy children if previous dose administered at age 24 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age	
Inactivated Poliovirus ⁶	6 wks	4 weeks	4 weeks	6 months ⁶	
Measles, Mumps, Rubella ⁷	12 mos	4 weeks			
Varicella ⁸	12 mos	3 months			
Hepatitis A ⁹	12 mos	6 months			
PERSONS AGED 7 THROUGH 18 YEARS					
Tetanus, Diphtheria/ Tetanus, Diphtheria, Pertussis ¹⁰	7 yrs ¹⁰	4 weeks	4 weeks if first dose administered at younger than age 12 months 6 months if first dose administered at 12 months or older	6 months if first dose administered at younger than age 12 months	
Human Papillomavirus ¹¹	9 yrs	Routine dosing intervals are recommended (females) ¹¹			
Hepatitis A ⁹	12 mos	6 months			
Hepatitis B ¹	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Inactivated Poliovirus ⁶	6 wks	4 weeks	4 weeks ⁶	6 months ⁶	
Measles, Mumps, Rubella ⁷	12 mos	4 weeks			
Varicella ⁸	12 mos	3 months if person is younger than age 13 years 4 weeks if person is aged 13 years or older			

1. Hepatitis B vaccine (HepB).

- Administer the 3-dose series to those not previously vaccinated.
- The minimum age for the third dose of HepB is 24 weeks.
- A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.

2. Rotavirus vaccine (RV).

- The maximum age for the first dose is 14 weeks 6 days. Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
- The maximum age for the final dose in the series is 8 months 0 days.
- If Rotarix was administered for the first and second doses, a third dose is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).

- The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.

4. Haemophilus influenzae type b conjugate vaccine (Hib).

- 1 dose of Hib vaccine should be considered for unvaccinated persons aged 5 years or older who have sickle cell disease, leukemia, or HIV infection, or who have had a splenectomy.
- If the first 2 doses were PRP-OMP (PedvaxHIB or Comvax), and administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
- If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a final dose at age 12 through 15 months.

5. Pneumococcal vaccine.

- Administer 1 dose of 13-valent pneumococcal conjugate vaccine (PCV13) to all healthy children aged 24 through 59 months with any incomplete PCV schedule (PCV7 or PCV13).
- For children aged 24 through 71 months with underlying medical conditions, administer 1 dose of PCV13 if 3 doses of PCV were received previously or administer 2 doses of PCV13 at least 8 weeks apart if fewer than 3 doses of PCV were received previously.
- A single dose of PCV13 is recommended for certain children with underlying medical conditions through 18 years of age. See age-specific schedules for details.
- Administer pneumococcal polysaccharide vaccine (PPSV) to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant, at least 8 weeks after the last dose of PCV. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition. See MMWR 2010;59(No. RR-11).

6. Inactivated poliovirus vaccine (IPV).

- The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
- A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months following the previous dose.
- In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).

7. Measles, mumps, and rubella vaccine (MMR).

- Administer the second dose routinely at age 4 through 6 years. The minimum interval between the 2 doses of MMR is 4 weeks.

8. Varicella vaccine.

- Administer the second dose routinely at age 4 through 6 years.
- If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

9. Hepatitis A vaccine (HepA).

- HepA is recommended for children aged older than age 23 months who live in areas where vaccination programs target older children, or who are at increased risk for infection, or for whom immunity against hepatitis A is desired.

10. Tetanus and diphtheria toxoids (Td) and tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).

- Doses of DTaP are counted as part of the Td/Tdap series.
- Tdap should be substituted for a single dose of Td in the catch-up series for children aged 7 through 10 years or as a booster for children aged 11 through 18 years; use Td for other doses.

11. Human papillomavirus vaccine (HPV).

- Administer the series to females at age 13 through 18 years if not previously vaccinated or have not completed the vaccine series.
- Quadrivalent HPV vaccine (HPV4) may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of genital warts.
- Use recommended routine dosing intervals for series catch-up (i.e., the second and third doses should be administered at 1 to 2 and 6 months after the first dose). The minimum interval between the first and second doses is 4 weeks. The minimum interval between the second and third doses is 12 weeks, and the third dose should be administered at least 24 weeks after the first dose.

Information about reporting reactions after immunization is available online at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967. Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for immunization, is available from the National Center for Immunization and Respiratory Diseases at <http://www.cdc.gov/vaccines> or telephone, 800-CDC-INFO (800-232-4636).

SCOTT AND WHITE HEALTH PLAN

CLINICAL PRACTICE GUIDELINE FOR THE TREATMENT OF OSTEOARTHRITIS OF THE KNEE

Scott and White Health Plan (SWHP) has adopted the “*Treatment of Osteoarthritis of the Knee (Non-Arthroplasty)*” dated December 6, 2008 of the American Academy of Orthopaedic Surgeons, as a clinical practice guideline for SWHP’s providers¹. The guideline is located at the following internet website:

<http://www.aaos.org/research/guidelines/OAKguideline.pdf>

Additional Resources for Care:

- **SWHP VitalCare Shared Decision-Making Program²:**
http://www.swhp.org/sites/default/files/SharedDecisionMakingRef_FAX.pdf
- **SWHP Formulary:** <http://www.swhp.org/homepage/providers/pharmacy>
- **Notes:**
 1. Specific recommendations for care should be discussed with your patient. All medications noted in this guideline may not be in the SWHP Formulary; however, since SWHP has an Open Formulary, non-Formulary medications are available with authorization at the non-Formulary copayment.
 2. SWHP’s Shared Decision-Making program offers preference-sensitive condition support. Preference-sensitive condition support extends to conditions for which either science supports multiple acceptable treatment options, or there is inadequate scientific information about the treatment choices. Our Health Coaches can help your patient make an informed decision about the treatment he or she would like to receive. Decision support for preference-sensitive conditions addresses a wide range of topics, including osteoarthritis.

SWHP Guideline Approval Body: SWHP Quality Improvement Subcommittee

Date of Adoption: March 8, 2011

Review Dates: N/A

Physician Sponsor: Mike Averitt, D.O.

Paper Copy: If you have difficulty downloading information or would like a paper copy, please contact SWHP Provider Relations Department toll-free at 800-321-7947 ext. 3064 or direct at 254-298-3064.

Complex Care Guidance Program

Scott & White Health Plan (SWHP) has a Complex Care Guidance Program to enhance our services to our Members and Providers. The mission of the SWHP Complex Care Guidance Program is to advocate for Members and to promote quality and cost-effective outcomes.

The Complex Care Guidance Program is staffed by a team of registered nurse case managers who strive to assist patients in achieving the greatest value possible from their health care plan. Case Managers facilitate arrangements to meet care needs for patients with chronic illnesses or catastrophic illnesses or injuries. Our program is holistic, patient-centered, and facilitates the transition of the patient to the most appropriate care setting along the continuum of care. Case Managers answer questions and provide education to help Members have a better understanding of their condition and plan of care. They also make referrals for patients to SWHP's Condition Guidance or, if indicated, case management for Behavioral Health issues.

Case Managers work with the physician, Member, and the family to set goals and develop a plan for self-management to assist the patient in achieving their previous or optimum health status.

Complex Care Guidance can assist the physician by supporting and reinforcing his/her plan of care, assisting in the coordination of services, and providing timely and meaningful information.

Participation is voluntary and is available at no additional cost to all SWHP Members.

To determine if Complex Care Guidance can benefit your patient, you may call 1-888-316-7947 or 254-298-3088 to submit a request for screening. You may also submit a request for screening at www.SWHP.org. Click on the Provider's tab and then click on Medical Management. Under Forms, select the Provider Referral Form under Case Management forms. Should you prefer a hard copy of the referral form, it can be printed from our website or contact us at either of the above numbers and we will be happy to provide you a copy of the referral form.

SWHP Utilization Management Criteria for Inpatient Services and Selected Benefit Coverage Determinations 2011

The SWHP Evidence of Coverage (EOC) [Standard Plan Document (SPD)] is the contract for coverage of the health care services that an individual or an employer has purchased for employees. SWHP provides a variety of benefit plans in order to meet the needs of the purchaser.

Some benefits are required by law to be offered through the Plan. Some services are not offered for various reasons (i.e., not felt to be a good value, or perhaps because the employer does not want an employee to share part of the costs of that care or service through their premium amount). SWHP's primary Utilization Management (UM) purpose is to manage services according to the terms contained in EOC/SPD. The medical necessity of the services is determined by the SWHP medical staff with input from the Member's physicians.

SWHP has adopted criteria reviewed by SWHP physician directors, network physicians and other providers for the year January 1, 2011 - December 31, 2011. These include InterQual® evidence-based criteria. SWHP also utilizes internal policies: (target length-of-stay (LOS)), Technology Assessment, and medical coverage policies. SWHP provided the InterQual® criteria, target LOS, and internally developed criteria (from Technology Assessment or policy and procedure enhancements through input from SWHP specialists) to the physician directors of Scott and White medical services divisions and various contracted network physicians in January 2011 for review and approval. Physicians were able to provide any comments to SWHP Utilization Management. Any changes received by January 17, 2011 were reviewed by the SWHP Medical Director(s) for consideration of incorporation depending on the issue. The resulting approved criteria sets and the target LOS were forwarded to the SWHP UM Committee for review and approval.

The criteria are used as a guideline only. All denials of coverage are made by the SWHP Medical Director(s). Any person making decisions on utilization management, including formulary coverage determinations, makes them based only on the appropriateness of care and services. No financial compensation is based on utilization of services or service denials. SWHP does not offer incentives, including compensations or rewards, to Practitioners or other individuals conducting utilization review.

SWHP is concerned that Members receive appropriate services, and monitors for evidence of under use, over use, and misuse. Individual coverage requests are discussed with the individual physician. SWHP UM staff is available by telephone 24 hours/7 days per week at 1-254-298-3088 or (toll free)

1-888-316-7947 or by appointment for discussion regarding UM and/or coverage determinations, including benefit provisions, guidelines, criteria or the processes used to make determinations. The above numbers are covered afterhours by the SWHP on call nurse with access to a Plan Medical Director.

Appeal rights, including expedited appeals, reconsideration rights and/or Independent Review Organization (IRO) options are always provided with any denial that is issued by SWHP. Ability to review the criteria is available to you by fax, phone, mail, email or through an onsite appointment with the Care Coordination Division Director (CCD) who can be reached by calling (toll free) 1-888-316-7947 or directly at 1-254-298-3088. Additionally, questions or requests related to any case-specific guidelines utilized in the process of making a benefit coverage determination or pharmacy determination can be directed to the CCD Director at the above numbers.

Scott & White Health Plan (SWHP) PROVIDER Quick Reference Card (QRC)



➤ **WEB SITE:** - www.swhp.org

➤ **MY PLAN:** SWHP's Provider Portal; access for verification of eligibility & claims status; to **register**, complete request form at this location and fax to Provider Relations: <http://www.swhp.org/homepage/providers/myplan-provider-module>

➤ **Referrals:** **SWHP no longer requires** referrals for claims payment; physicians may, in their course of treatment, require one

➤ **Prior Authorization (PA):** an approval obtained in advance of services rendered. This is required for any out of network services, high cost services, in patient stays and some medical services that are not normally covered under the Provider Agreement. To obtain PA, complete the form found here <http://www.swhp.org/homepage/providers/provider-forms> and fax to Health Services. To determine if you need a PA, contact Provider Relations

➤ **Electronic Claims** - in order to bill SWHP electronically, Availity must be used (both professional and institutional claims) SWHP Payor ID is: 88030. The filing deadline is 95 days. Appeals are 45 days; find more information here along with appeal form: <http://www.swhp.org/homepage/providers/provman#C&B>

➤ **Pathology, Radiology, and Cardiography:** a listing of approved CPT codes for a physician's office can be found in your contract. All other PATH, RAD, and CARD services should be referred to contracted organizational providers. These providers are located in the on-line Provider Directory: http://www.swhp.org/homepage/providers/provider_certification

➤ **Durable Medical Equipment (DME)** / Supplies allowed by SWHP to be distributed by a Practitioner's Office are located in the on-line Provider Manual under the Physician's Office DME/Supplies Policy section.

➤ **Specialty Drug Forms & RX Formularies** can be found here: <http://www.swhp.org/homepage/providers/provman#pharm>

➤ **Online Orientation:** <http://www.swhp.org/homepage/providers/orientation/checklist>



FORMS: a quick link to the most commonly used provider forms: <http://www.swhp.org/homepage/providers/provider-forms>

Member Rights and Responsibilities: <http://www.swhp.org/homepage/providers/provman>

➤ **CONTACT US** telephonic inquiries - <http://www.swhp.org/homepage/providers/contact-info-for-providers>

Scott & White Health Plan (SWHP) PROVIDER Quick Reference Card (QRC)

CONTACT INFORMATION

Provider Relations

Phone: (254) 298-3064

Fax: (254) 298-3044

Email: SWHPPROVIDERRELATIONSDEPARTMENT@swmail.sw.org

Health Services Division (Out-of-Plan Referrals, Prior Authorization)

(888) 316-7947 or (254) 298-3088

Fax Server Number: (800) 626-3042 or (254) 298-3450

Member Eligibility/Benefits Verification

(800) 321-7947 or (254) 298-3000

Claims (Status Checks and Claims Inquiries)

(800) 321-7947 or (254) 298-3000



SWHP HIPAA 5010 Compliance Plan

This publication contains information pertaining to the migration of specific HIPAA transactions from version 4010A1 to 5010. SWHP shall provide updates to this information as change become necessary. Please alert the appropriate HIPAA 5010 Compliance personnel in your organization.

The table below is our schedule projection for HIPAA 5010 Compliance testing:

Transaction Set	Description	Level 1 Test Dates	Level 2 Test Dates	Compliance Target Dates
834	Benefit Enrollment and Maintenance	July, 2011	July, 2011	January 1, 2012
835	Payment/Remittance Advice	July, 2011	July, 2011	January 1, 2012
837i/837p	Professional & Institutional Claim	July, 2011	July, 2011	January 1, 2012
999	Acknowledgement	July, 2011	July, 2011	January 1, 2012

If you have any HIPAA 5010 compliance-related questions, please contact either of the following people at SWHP:

1. Troy Stillwagon - SWHP MIS Vice President - Tstillwagon@swmail.sw.org
2. Noel Rivas - SWHP MIS Director - Nrivas@swmail.sw.org
3. Michael Moore - Project Manager - Mimoore@swmail.sw.org

LEGISLATION PASSED ORALLY ADMINISTERED ANTICANCER MEDICATION MANDATE EFFECTIVE JANUARY 1, 2012

June 28, 2011 Temple Telegram ran a story about the Orally Administered Anti-cancer Medication mandate that passed in the legislative session. The mandate takes effect as plans renew on or after January 1, 2012. Also, it does not apply to Consumer Choice plans.

Basically, the mandate requires SWHP to cover an orally administered medication on the same basis (or more favorable) as SWHP would cover an IV or injected cancer medication under our medical benefit. SWHP will require pre-authorization.

SWHP has provided the below copy of the bill signed by the governor and a link to the bill: <http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/HB00438F.htm>

AN ACT

relating to health benefit plan coverage for orally administered anticancer medications.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Chapter 1369, Insurance Code, is amended by adding Subchapter E to read as follows:

SUBCHAPTER E. COVERAGE FOR ORALLY ADMINISTERED ANTICANCER MEDICATIONS

Sec. 1369.201. DEFINITIONS. In this subchapter:

- (1) "Health benefit exchange" means an American Health Benefit Exchange administered by the federal government or created pursuant to Section 1311(b), Patient Protection and Affordable Care Act (42 U.S.C. Section 18031).
- (2) "Qualified health plan" has the meaning assigned by Section 1301(a), Patient Protection and Affordable Care Act (42 U.S.C. Section 18021).

Sec. 1369.202. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501 or coverage provided by a health group cooperative under Subchapter B of that chapter, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) an exchange operating under Chapter 942;
- (6) a Lloyd's plan operating under Chapter 941;
- (7) a health maintenance organization operating under Chapter 843; or
- (8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Sec. 1369.203. EXCEPTION. (a) This subchapter does not apply to:

- (1) a plan that provides coverage:
 - (A) only for fixed indemnity benefits for a specified disease or diseases;
 - (B) only for accidental death or dismemberment;
 - (C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
 - (D) as a supplement to a liability insurance policy;
 - (E) only for dental or vision care; or
 - (F) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by

Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

- (3) a workers' compensation insurance policy;
- (4) medical payment insurance coverage provided under an automobile insurance policy;
- (5) a credit insurance policy;
- (6) a limited benefit policy that does not provide coverage for physical examinations or wellness exams;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (8) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.201.

(b) This subchapter does not apply to a qualified health plan offered through a health benefit exchange.

Sec. 1369.204. REQUIRED COVERAGE FOR ORALLY ADMINISTERED ANTICANCER MEDICATIONS.

- (a) A health benefit plan that provides coverage for cancer treatment must provide coverage for a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits by the plan.
- (b) This section does not prohibit a health benefit plan from requiring prior authorization for an orally administered anticancer medication. If an orally administered anticancer medication is authorized, the cost to the covered individual may not exceed the coinsurance or copayment that would be applied to a chemotherapy or other cancer treatment visit.
- (c) A health benefit plan issuer may not reclassify anticancer medications or increase a coinsurance, copayment, deductible, or other out-of-pocket expense imposed on anticancer medications to achieve compliance with this section. Any plan change that otherwise increases an out-of-pocket expense applied to anticancer medications must also be applied to the majority of comparable medical or pharmaceutical benefits under the plan.
- (d) This section does not prohibit a health benefit plan issuer from increasing cost-sharing for all benefits, including anticancer treatments.

SECTION 2. Subchapter E, Chapter 1369, Insurance Code, as added by this Act, applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2012. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2012, is covered by the law in effect at the time the plan was delivered, issued for delivery, or renewed, and that law is continued in effect for that purpose.

SECTION 3. This Act takes effect September 1, 2011.

President of the Senate Speaker of the House

I certify that H.B. No. 438 was passed by the House on April 21, 2011, by the following vote:
Yeas 147, Nays 1, 1 present, not voting.

Chief Clerk of the House

I certify that H.B. No. 438 was passed by the Senate on May 10, 2011, by the following vote:
Yeas 31, Nays 0.

Secretary of the Senate

APPROVED: _____
Date

Governor



ANNOUNCEMENTS FROM PROVIDER RELATIONS MEDICARE CROSS OVER CLAIMS NOW ACCEPTED!

Effective 5/1/2011, SWHP began accepting cross over claims from Medicare ((COBA). If you bill secondary claims to SWHP for Medicare primary claims, we are now receiving daily electronic files from Medicare (COBA) and will be processing provider payments from these electronic Medicare submissions. **No need to submit a paper claim to SWHP for secondary claims processing.**

PROVIDER SATISFACTION SURVEY

Scott & White Health Plan Provider Relations would like to invite you to participate in our online provider satisfaction survey, going on now through September 30, 2011. Your comments and feedback are important to us. For your time and effort, we are entering all names of those who submit a response in a drawing for multiple **\$50 gift cards**. Winners will be announced at the end of August but you must be an active contracted physician or **represent** a contracted physician with Scott & White Health Plan at the time you submit your survey. If you do not have access to a computer, please contact us at (254) 298-3064 and we will send you a paper copy for submission.

Please go to this link to find the survey:

<https://www.surveymonkey.com/s/swhpproviders>

Thank you for your commitment to serving our members, your patients.

Member's Rights and Responsibilities Policy and Procedure

Revised 6/07

To see revisions go to www.swhp.org

- click Providers tab
- click General Information
- click Member's Rights and Responsibilities-Policy and Procedures

**Paper copy available by contacting Customer Service @ 1-800-321-7947 ext 3000*



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