Diabetes Management Resources

A provider's guide to empowering your patients with diabetes.

SuperiorHealthPlan.com/diabetes-help

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As your partner, Superior HealthPlan is committed to providing the tools you need to deliver the best quality of care. This booklet details the Superior resources that are available for the treatment and care for members with diabetes.

Patient Resources

Care Management Services

Members who meet certain criteria (detailed below) are eligible for Superior's Care Management services. Superior adheres to the Case Management Society of America's (CMSA) definition of care management as "a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes."

Levels of Care Management

Care Coordination

Members with psychosocial issues, such as housing or financial, that need assistance with accessing health care are eligible for Care Coordination. Care Coordination involves non-clinical activities performed by non-clinical staff and includes outreach to members in an effort to provide assistance with scheduling appointments and securing authorizations, as well as following up with members to ensure compliance.

Care Management

Care Management serves members with clinical needs, including complex conditions or co-morbidities, which require a higher level of service. These members typically have adequate family or other caregiver support and are in need of moderate to minimal assistance from a Care Manager. Services include member outreach in the form of identifying, setting and making progress on defined health-care goals.

Complex Care Management

Members with complex medical and/or psychosocial needs, including special care or serious and/or persistent mental illness, are eligible for Complex Care Management. Superior provides Complex Care Management for members that have experienced a critical event or have a complex diagnosis requiring oversight and coordination to ensure members receive the appropriate services and care. Complex Care Management includes frequent outreach to assist members in developing and working to meet defined health-care goals.

If you think any of your Superior patients would benefit from these services, please direct them to call Member Services at the number on the back of their ID card.

Participation Criteria

- Recent inpatient or emergency room utilization as a result of uncontrolled diabetes.
- Demonstrated difficulty with adhering to treatment plan, resulting in disease progression.
- Unresolved barriers affecting optimal management of disease process or disease progression.
- Demonstrated need for more intensive, holistic management to address the member's disease process.

Patient Resources

Diabetes Mellitus Subject Matter Experts (DM SME)

Subject Matter Experts (SME) are available as a support system for Superior Care Managers (CMs). These experts have additional training on diabetes management. Superior has Diabetes Mellitus (DM) SMEs that the CMs have access to in order to improve the Care Management of diabetic members and reduce gaps in care. The goal is to help the member become successful in their journey to self-management of DM. The intended outcome will lead to reductions in diabetes related complications, decreases in Potentially Preventable Events (PPE), DM focused care planning, care coordination and disease management resulting in improved utilization of benefits and services.

Diabetes Disease Management

Superior's Disease Management Program teaches members how to help manage a chronic disease like diabetes. Members enrolled in this program learn how to manage their diabetes to avoid potential problems or worsening of their condition.

Superior's Disease Management services include member outreach (telephonic or direct mail) to help identify, set and meet member health-care goals. Members enrolled in Disease Management may receive more frequent outreach to assess adherence to their treatment plan and progress towards goal attainment. Superior Care Managers also monitor the member's key indicators of disease progress (e.g. HbA1c levels).

Participation criteria may include:

- Recent or multiple hospitalizations related to diabetes.
- A pattern of increased blood sugar levels.
- New onset diabetes complications or an increase in symptoms.
- Initiation of insulin therapy.

Depression Disease Management

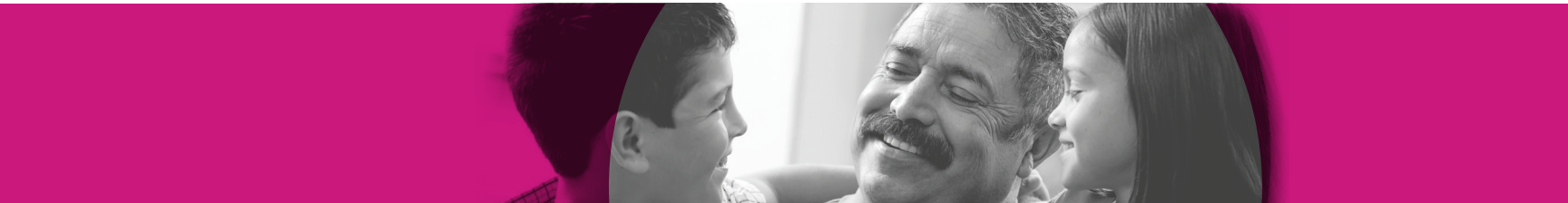
Depression frequently occurs in tandem with chronic medical illnesses such as heart disease, Chronic Obstructive Pulmonary Disease (COPD), chronic pain or diabetes, which complicates the treatment of both. Identifying members with depression, and providing treatment in an evidence-based depression care program, has proven to result in increased member adherence to treatment and reduced medical costs.

Superior's Depression Disease Management Program helps members with depression achieve the highest possible levels of wellness, functioning and quality of life with the goal of reducing depressive symptoms and improving medication adherence. Employing multiple communication strategies, the Care Managers support and collaborate with Primary Care Physicians (PCPs) to ensure members receive the most effective and efficient resources, coupled with the best overall behavioral and physical health outcomes.

Participation criteria:

- A member may self-refer to Superior's Depression Disease Management Program or be referred by Superior Care Management staff or a treating practitioner.

To refer a member for Disease Management services, call 1-800-905-6970.



Quality Improvement Initiatives

Home Health Assessments

Superior has partnered with several companies to perform in-home assessments and laboratory draws for members at no cost. A health-care professional (nurse practitioner, physician assistant and/or a phlebotomist) contacts eligible members to schedule the appointment, which may include health evaluations and the collection of blood, stool and/or urine samples, height, weight and blood pressure. The information from the visit is shared with the PCP so they can work with the member to create a treatment plan.

Pharmacy Management and Interventions

The Superior Pharmacy department utilizes data and claims to retrieve diabetes medication adherence information for members. Adherence concerns are triaged based on the proportion of days covered, or PDC calculation. Superior uses a multi-pronged outreach approach, involving the member, provider and pharmacy to ensure medication adherence. Providers are notified about the adherence concern and may be contacted to assist with new prescription requests. The member is also provided notification, by appropriate parties, to review the prescribed oral diabetic medication and barriers to taking the medication. Multiple options for addressing these concerns include use of mail order, adherence packaging, medication synchronization, pill boxes or 90-day supply benefits when available. Members are connected with the local pharmacy or mail order pharmacy when refill requests are needed.

In addition, claims are reviewed for members missing Angiotensin Receptor Blockers (ARBs) or Angiotensin Converting Enzyme (ACE) inhibitors which can support the prevention of diabetic nephropathy. The American Diabetes Association recommends that pharmaceutical treatment for a patient with diabetes include an ACE or ARB. It is recommended that if one medication class is not tolerated, the other class be substituted. The Pharmacy team works with appropriate parties to contact providers if a member is missing the ACE or ARB from their medication claims. During provider outreach, the pharmacist will recommend that the provider review and prescribe the missing treatment as part of an overall diabetic treatment plan. In addition, the Pharmacy team may share these claim reports and gaps in care concerns with the Care Management teams.

Referral to a Specialist

BRIDGES to Excellence®
Recognizing Quality across the Healthcare System

Through Superior's Bridges to Excellence (BTE) Diabetes Care Recognition Program, members and providers can identify physicians, including endocrinologists, PCPs and diabetologists, who deliver top care to patients with diabetes. BTE is a physician recognition program designed to measure the quality of care delivered with a focus on managing patients with chronic conditions. Doctors must meet certain standards to be selected for the BTE Program. BTE doctors are recognized for providing the highest level of care for their patients with diabetes. These doctors meet standards set forth by organizations like the American Diabetes Association, the American Heart Association and the American Stroke Association. For information on BTE recognition, visit www.SuperiorHealthPlan.com/BTE.

Preferred Diabetic Meter Program

Superior has a preferred diabetic meters specific to program for Medicaid, CHIP and Allwell from Superior HealthPlan. These preferred meters use diabetic test strips which may be subject to copay depending on plan design for certain Medicare and CHIP members. Certain non-preferred meters, such as a talking meter used for vision impairment, may require prior authorization. STAR Kids and STAR+PLUS members with Intellectual and Development Disabilities (IDD) that are currently in their Continuity of Care (COC) phase will not be required to use the preferred meter until they complete their individual COC period.

Please see the Superior HealthPlan website for more information on the preferred diabetic meters for your program type.

Questions?

Please contact the Superior Pharmacy department, Monday – Friday from 8 a.m. – 6 p.m., at 1-800-218- 7453, ext. 22080.

Provider Resources

3M Health Information Systems

3M Health Information Systems (HIS) is a health-care analytics software suite that provides practitioners with data about the quality and access to care within their practice. 3M HIS features a user-friendly dashboard that helps to provide information to improve performance, manage costs and promote quality of care by providing insight into actual patterns of care within a provider's patient populations. The tool assigns a Value Index Score (VIS), which is a single composite score that shows how the provider's overall quality of care ranks, relative to all other providers in the network. The VIS is comprised of 16 quality measures, many of which are drawn from the Healthcare Effectiveness Data and Information Set (HEDIS). For more information visit: www.SuperiorHealthPlan.com/for-providers/provider-resources/training/.

3M HIS Reports

Each month, the following five reports are refreshed and reported through the tool:

1. **Population report**: assists the PCP in understanding the clinical category and risk of attributed members
2. **Value Index Score**
3. **Care management gap report**: helps the PCP in understanding gaps in care for members
4. **Patient profile report**: provides detailed information on each attributed member
5. **Inpatient notification report**: provides information on members who were admitted to the hospital

Practice Guidelines

At Superior, network providers play an essential role in the coordination of care and the member care experience. Superior encourages providers to be actively involved in the member care experience by maximizing resources available to them and adopting Superior's practice guidelines. Superior bases its practice guidelines upon optimal potential for improving health outcomes or the quality of service delivered to Superior members, as identified by Superior's Quality and Performance Improvement (QAPI) Program. Superior adopts, approves and promotes preventive and practice guidelines published from nationally recognized organizations, government institutions and statewide initiatives that are evidence-based for use by providers in an effort to ensure health-care quality and uniformity for Superior members. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. Practice Guidelines may be found at www.SuperiorHealthPlan.com/providers/resources/quality-improvement/practice-guidelines.html.

Bridges to Excellence

Bridges to Excellence (BTE) is a physician recognition program from Health Care Incentives Improvement Institute (HCI3) designed to measure the quality of care delivered with a focus on managing patients with chronic conditions. To address the widespread diabetes issue in Texas, Superior is now a proud partner of HCI3's Bridges to Excellence® Diabetes Care Recognition Program. The BTE Diabetes Care Recognition Program is intended to identify clinicians who deliver high-value care to patients with diabetes. Superior has an incentive program to reward physicians who have achieved recognition in the BTE Diabetes Care program.

BTE has recognition programs for health-care professionals who work with asthma, cardiac, CHF, cardiology, COPD, CAD, AGA IBD, depression, diabetes, hypertension, physician office, spine and medical home. Each program has three levels of recognition: I, II and III, each indicating a different performance level. Once recognized, physicians are eligible for incentive programs from health plans, like Superior.

For information on BTE recognition and the incentive program, visit www.SuperiorHealthPlan.com/providers/resources/provider-programs/bridges-to-excellence.html.

Studies of the BTE program demonstrate that participation in BTE programs leads to improved physician performance, better patient health and reduced costs of care.

HEDIS Quick Reference Guides

HEDIS Quick Reference Guides are available for providers and their staff. These guides describe key HEDIS measures and provide guidance on how to appropriately bill for services. Superior reminds providers to always follow the state and/or Centers for Medicare and Medicaid (CMS) billing guidance and ensure the HEDIS codes are covered prior to submission. Below is a sub-section from the HEDIS Guide on important CPT codes.

DIABETES CARE *(Comprehensive)*

Measure demonstrates the percentage of members ages 18-75 with diabetes (types 1 & 2) who were compliant in the following submeasures:

HbA1c Test: is completed at least once per year (includes rapid A1c).

CPT	CPT II	HCPCS
URINE PROTEIN TESTS: 81000-81003, 81005, 82042-82044, 84156	URINE PROTEIN TESTS: 3060F-3062FNEPHOPATHY TREATMENT: 3066F, 4010F	KIDNEY TRANSPLANT: S2065, G0257, S9339

Required documentation to ensure compliance with HbA1c testing:

- HbA1c done in measurement year
- Documentation of HbA1c result with corresponding date of service

Eye Exam: a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) is completed every year OR a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior OR bilateral eye enucleation anytime during the member's history, through December 31 of the measurement year. Practitioners who are not eye-care professionals may indicate a low risk for retinopathy due to a negative retinal exam the year prior by using CPT II code 3072F.

CPT	CPT II	HCPCS
67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245	2022F, 2024F, 2026F, 3072F	S0620, S0621, S0625, S3000

Nephropathy Screening Test: a urine protein test to screen for nephropathy is performed at least once per year. A member who is being treated for nephropathy (on ACE/ARB), has evidence of End Stage Renal Disease (ESRD), stage 4 chronic kidney disease, a history of a kidney transplant or is being seen by a nephrologist is compliant for this submeasure.

CPT	CPT II	HCPCS
81000-81003, 81005, 82042-82044, 84156	3060F-3062F, 3066F, 4010F	—

BP Control: BP readings taken during an outpatient visit may be used to monitor BP control.

CPT	CPT II	HCPCS
OUTPATIENT VISIT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429, 99455-99456,99483 NONACUTE INPATIENT: 99304-99310, 99315,99316, 99318, 99324-99328,99334-99337 REMOTE BLOOD PRESSURE MONITORING: 93784, 93788, 93790, 99091	SYSTOLIC: <140: 3074F, 3075F SYSTOLIC: >/= 140: 3077F DIASTOLIC: <80: 3078F DIASTOLIC: 80-89: 3079F DIASTOLIC: >/=90: 3080F	OUTPATIENT VISIT: G0402, G0438-G0439, G0463, T1015