Physician Satisfaction Survey: Tell Us What You Think

UnitedHealthcare Community Plan is committed to making sure that our service and programs support your practice in providing quality care to your patients who are our members. We value and seek administrative simplicity that takes the hassles out of clinical practice and reduces inefficiency and waste. For this reason, we periodically offer a random sample of network physicians the opportunity to provide feedback on our services.

Next month, August 2012, UnitedHealthcare Community Plan will launch its annual Physician Satisfaction survey. You may receive an invitation to complete the survey allowing you to evaluate the services and programs provided to your practice.

Your opinions will help identify and prioritize opportunities for improvement and assess the level of satisfaction with our health plan. This feedback is critical in helping us to better meet the needs of your practice. Your input will help us create simpler and innovative solutions for you and your practice. If you receive the survey, we appreciate your time and support and thank you for your feedback.

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For more information

Call our Provider Service Center at 800-557-9933
Visit UHCCommunityPlan.com
Ensuring Satisfaction

Employees who represent Our United Culture are what make the UnitedHealth Group community special and unite us in our mission to help people live healthier lives — and we want to share their stories.

Joseph Tullmann

Joseph Tullmann, a customer care professional on OptumHealth’s Behavioral Solutions team in Maryland Heights, Missouri, embodies our culture by patiently and compassionately building relationships with our provider partners. OptumHealth Behavioral Solutions works with providers to coordinate behavioral health services that help adults and children on Medicaid obtain high-quality care at the right time and place. Recently, a provider sent the following message in response to his experience with Joseph.

“I spoke with Joe today and he was able to answer all of my questions. I can say I have never had an experience like this dealing with any insurance company. He was thorough and patient. I don’t consider myself to be a difficult person, but I had some difficult questions and he was able to answer all of them. Joe did a phenomenal job and I really appreciate it.”

Thank you, Joseph, for your commitment to excellent service by ensuring our customers feel understood, informed and satisfied.

Submitting Claims Electronically

Did you know by converting 10,000 paper claims, remittance advice, and reimbursements to electronic transmittal (EDI, EFT, and ERA) we could:

• Save 3729 pounds of paper
• Eliminate 148,389 pounds of greenhouse emissions (Equivalent to 1726 new trees grown for 10 years or 20,451 square feet of forest conserved)
• Average Practice can save thousands of dollars per year by converting to electronic transmission.

*Source: www.payitgreen.org

Getting Started with EDI is simple

To submit claims electronically: have your office software vendor or clearinghouse make connection to UnitedHealthcare’s clearinghouse OptumInsight.

OptumInsight.com
800-341-6141

UnitedHealthcare
Community Plan Payer ID: 95378

Contact our EDI
Department to learn about no cost solutions for EDI
UnitedHealthcare Community Plan EDI Support Services
800-210-8315
ac_edi_ops@uhc.com
UHCCommunityPlan.com/health-professionals

Submit single or batch claims directly to us through the secure Provider Portal by going to UHCCommunityPlan.com/health-professionals

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Receive Payment for claims electronically (EFT)
EFT is safe, secure, efficient, and more cost effective than paper claim payments. You can find the EFT enrollment form on our website, if you would like to save money and time, enroll today! Enrollment forms can be found at www.uhccommunityPlan.com/health-professionals > State > EDI Section

Receive Remittance Advice Electronically (ERA)
To enroll in ERA contact your software vendor and/or clearinghouse

COB (Secondary) EDI Claims Submissions are preferred electronically
- Please refer to the 837 Companion Guide located on our website or simply call our EDI Support services at 800-210-8315 or email us at ac_edi_ops@uhc.com we would be happy to assist with setup.
- Do not send paper claim backup for claims that have already been submitted Electronically

Electronic Claim Submission Tips
- Include your tax identification number (TIN) along with your NPI number
- Member ID Numbers are required
- The Payer ID number indicates where clearinghouses should direct their claims.

The use of Progesterone in the Prevention of Preterm Births
by Gordon B. Kuttner, MD, Sr. National Medical Director at UnitedHealth Group

Preterm birth is defined as birth occurring prior to 37 completed weeks of gestation. The burdens that commonly result from preterm births are emotional and financial, short-term and long-term. Preterm births may result in developmental delays, life long disabilities, and serious medical complications including cerebral palsy, sensory deficits, chronic lung disease, blindness, and hearing loss. More than one-third of deaths occurring within the first year of life are attributable to preterm-related causes. In 2005, the Institute of Medicine estimated that preterm births cost the U.S. at least $26.2 billion ($51,600 for every infant born prematurely). These costs include medical and educational expenses and associated loss of productivity.

There are multiple causes for preterm births. Causes of preterm birth are both iatrogenic (appropriate and inappropriate) and spontaneous. By now, most providers of obstetrical services are aware of the increased risks of delivering a baby prior to 39 weeks gestation without a medical maternal or fetal indication. Additionally, most caregivers are familiar with the use of progesterone injections for the prevention of spontaneous premature births. As with any condition, the appropriate choice of treatment is dependent on factors inherent in each patient. This appears true with progesterone and its use in two separate high risk populations: (1) those with a singleton pregnancy who have a short cervix and (2) those women with a singleton pregnancy who had a prior spontaneous singleton, live born, preterm delivery associated with preterm labor between 20.0 and 36.6 weeks with a normal cervical length in the current pregnancy.

The two risks factors for spontaneous preterm births (SPB) respond differently to different forms and routes of administration of progesterone. Based on the current research (which is constantly evolving):
Short Cervix (< 25 mm): responds to the use of micronized progesterone vaginal gel (and to a lesser extent compounded vaginal suppositories), but does not respond to 17 Alpha-Hydroxyprogesterone Caproate (17P) injections. Micronized progesterone vaginal gel (and compounded vaginal progesterone) appears to benefit those pregnancies that are found to have a short cervix, regardless of whether they have a history of SPB. A meta-analysis by Romero (see below) evaluated multiple gestations and revealed no benefit in reduction in PTBs or NICU admissions, but did see a benefit on composite neonatal morbidity and mortality.

History of SPB with Normal Cervical Length: responds to the use of 17 Alpha-Hydroxyprogesterone Caproate (17P) injections for singletons and not multiples. 17P injections have not been proven to decrease preterm birth in women with a short cervix who have not had a PTB. Those with a prior history of a SPB and short cervix in the current pregnancy appear to benefit from only vaginal micronized progesterone without 17P injections.

Short Cervix

In an article published in the February 2012 issue of American Journal of Obstetrics & Gynecology, Romero and colleagues, with funding from the NICHD, NIH, and DHHS, performed a systematic review and meta-analysis of individual patient data demonstrating that treatment with vaginal progesterone in women with asymptomatic ultrasonic short cervix (< 25 mm) in the midtrimester (19 0/7–23 6/7 weeks gestation) results in a decrease in preterm delivery and composite neonatal morbidity/mortality, NICU admissions, mechanical ventilation and respiratory distress syndrome. Five trails with 775 women and 825 infants were used. Singletons represented 93.3% pregnancies and 6.7% were twin pregnancies. In 3 of the 5 studies cerclage was allowed after randomization. There was a significant reduction in the rate of PTB < 33 weeks (RR 0.58, 95% CI 0.42–0.80), < 35 weeks (RR 0.69, 95% CI 0.55–0.88), and 28 weeks (RR 0.57, 95% CI 0.40–0.81). There was also a significant reduction in composite neonatal morbidity and mortality (RR 0.50, 95% CI 0.30–0.81) and admissions to the NICU (RR 0.75, 95% CI 0.59–0.94). The number of patients with a short cervix who needed to be treated (NNT) to prevent one case of PTB < 33 weeks was 11 (95%, CI 8–23), < 35 weeks, 11, < 34 weeks 9, and < 28 and 30 weeks, 18. With regard to singleton and twins gestations, there were significant reductions in PTB < 33 weeks in only the singleton group, 44% reduction vs placebo (CI 0.4–0.8). Additionally, NICU admission reductions, 33%, were statistically significant only in the singleton pregnancies (CI 0.5–0.91).

However, both singletons and twins showed a statistical reduction in composite neonatal morbidity and mortality. Vaginal progesterone was associated with a significant reduction in PTB < 33 weeks in both women with a singleton gestation with no previous PTB (RR 0.60, 95% CI 0.39–0.92) as well as those with a singleton pregnancy and at least one prior PTB between 20–37 weeks (RR 0.54, 95% CI 0.30–0.98).

American College of Obstetricians and Gynecologists (ACOG) released Committee Opinion No. 522 (April 2012) on incidentally detected short cervical length. ACOG’s Committee on Obstetric Practice recommends the following management options to reduce the risk of preterm birth in women with incidentally detected short cervical length:

• Cervical length screening by transvaginal (not transabdominal) ultrasound examination has been proven to help predict preterm birth. The utility of universal cervical length

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 screening for the prevention of preterm birth is controversial and being debated.

- In asymptomatic women with singleton gestations without prior preterm birth with an incidentally identified very short cervical length < 20 mm before or at 24 weeks of gestation, vaginal progesterone (200-mg micronized or 90-mg gel) may be considered to reduce the risk of preterm birth.

- Women with singleton gestations with PTB of a prior spontaneous, singleton, live born, and associated with preterm labor or spontaneous rupture of membranes between 20.0 and 36.6 weeks should be offered progesterone supplementation, regardless of cervical length measured by transvaginal ultrasound examination, starting at 16 weeks of gestation.

- Cerclage for women with a singleton pregnancy, prior preterm birth at less than 34 weeks of gestation, and short cervical length < 25 mm before 24 weeks of gestation is associated with perinatal benefits and significant decreases in preterm birth outcomes and may be considered.

- There are insufficient data on the efficacy of interventions for the prevention of preterm birth in women with multiple gestations with both a prior preterm birth and a short cervical length. Cerclage may increase preterm birth in women with a twin pregnancy and a cervical length of < 25 mm and is not recommended at this time.

**History of SPB**

From the time the Meis article was published in the New England Journal of Medicine in 2003, many other studies have confirmed the benefit in PTB reduction using 17 Alpha-Hydroxyprogesterone Caproate (17P). Several studies have looked at the use of vaginal progesterone in various delivery systems. There is now significant evidence that in those with a history of a PTB and a current singleton pregnancy with a short cervix may benefit from vaginal progesterone alone. There is clear evidence from the literature that 17P IM does not change outcomes when administered to women with multiple gestations.

**Indications for 17 Alpha-Hydroxyprogesterone Caproate (17P) IM**

Asymptomatic women with at least one prior spontaneous (without medical cause for delivery or due to cervical insufficiency), singleton, live born, with or without ruptured membranes, preterm delivery between 20.0 and 36.9 weeks associated with preterm labor and initiating the medication between 16.0 and 26.9 weeks. (UnitedHealthcare Drug Policy number 2011D0040A)

**Indications for Micronized Progesterone Vaginal Gel or Compounded Vaginal Progesterone**

Asymptomatic women with a singleton pregnancy and an ultrasound demonstrated short cervix (< 25mm; [ACOG < 20 mm]) diagnosed between 19.0 and 23.9 weeks of gestation and initiating the medication between 20.0 and 23.9 weeks gestation.

**UnitedHealthcare Community Plan's Take Home Message:**

1. Short cervix alone and short cervix with a history of PTB both respond to a minimum of 90 mg of micronized progesterone vaginal gel every morning or compounded 200 mg progesterone vaginally prior to sleep. There are no studies to suggest better outcomes with the treatment of those with short cervix with a history of PTB with combined vaginal progesterone and 17P.

2. History of PTB with a normal cervical length has been proven to respond to 250 mg of 17P IM weekly and not vaginal progesterone.
import information for heath care professionals and facilities

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3. For those currently pregnant with twin gestations with or without short cervix treated with vaginal progesterone or 17P, there is no decrease in the rate of PTB or NICU admissions.

4. For those currently pregnant with twin gestations with a short cervix treated with vaginal progesterone there is a statistical reduction in composite neonatal morbidity and mortality, but not rate of PTB.

5. Cervical length screening by transvaginal (not transabdominal) ultrasound examination has been proven to help predict preterm birth. Although the utility of universal cervical length screening for the prevention of preterm birth is controversial and being debated, there appears to be a benefit to screening pregnant women with singleton pregnancies with transvaginal ultrasound measurement for cervical length performed by trained personnel between 19 and 24 weeks of gestations and treatment with 90 mg of micronized progesterone vaginal gel daily or compounded 200 mg progesterone vaginally daily for those found to have a cervical length < 25 mm [ACOG < 20 mm] until 36 6/7 weeks of gestation.

UnitedHealthcare Community Plan supports the appropriate treatment for the appropriate patient. For those members that meet the criteria for 17P and do not have a State sponsored pharmacy benefit, UnitedHealthcare Community Plan has a preferred relationship with Walgreens Specialty Pharmacy. Walgreens Specialty Pharmacy will ship compounded, preservative-free 17P to a provider’s office and bill UnitedHealthcare Community Plan directly. Walgreens Specialty Intake staff can be reached at Phone: 888-347-3415, Fax: 888-347-3417.

Additionally, UnitedHealthcare has a preferred relationship with the Women’s and Children’s Health division of Alere Health. This home health service offers a compounded, preservative-free 17P administration program, which includes in-home obstetric nurse administration, education about the risk factors and signs and symptoms of preterm labor, weekly assessments and 24/7 nurse-line support. For more information please contact Alere at 800-950-3963.

UnitedHealthcare Community Plan requires prior authorization for compounded 17P whether administered in the office or by a home health service. Although 17P is a medication, it is covered under the medical and not pharmacy benefit because it is not a self-injectible medication. At this time micronized progesterone vaginal gel is covered by the pharmacy benefit and requires prior authorization, unless the member is covered by a State Fee-for-Service Pharmacy Program and lives in Louisiana, Tennessee, Nebraska, Delaware, Texas, or Wisconsin. Authorizations are based on medical necessity, which is determined by the drug policy, evidence-based medicine, state benefits, regulations, contracts and medical judgment. For UnitedHealthcare Community Plan members who do not have a State Fee-for-Service Pharmacy Program, 17P and micronized progesterone vaginal gel will be covered under the patient’s medical or pharmacy benefit, respectively, in accordance with their coverage.

For more information regarding the use of 17P IM please view the online provider bulletin at www.uhccommunityplan.com and select 17 Alpha-Hydroxyprogesterone Caproate (17P) Information with links to the UnitedHealthcare Drug Policy number 2011D0040A.

Physicians and health care providers may request clinical review criteria used to make coverage decisions. Please contact the Pharmacy Prior

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Notification department at 1-800-310-6826 to request clinical review criteria.


Cooperation of Care between Primary Care Physicians and Specialists

UnitedHealthcare wants to underscore the importance of ongoing communication between Primary Care Physicians and Specialists. Below, please find information and suggestions on ways to keep the lines of communication open to support the best care possible for your patients who are UnitedHealthcare members.

Primary Care Physicians and specialists share responsibility for communicating essential patient information regarding consultations and referrals. Both groups agree that failure to consistently communicate threatens their ability to provide high-quality care. According to a recent study, there is a difference of opinion among providers regarding the frequency of information provided and received. Though 69.3% of primary care physicians said they send specialists notification of a patient's history, and the reason for the consultation all or most of the time, just 34.8% of specialists said they routinely receive such information, according to the study. Meanwhile, 80.6% of specialists say they send consultation results to the referring physician all or most of the time, but only 62.2% of Primary Care Physicians say they ever get that information. (Arch Intern Med. 2011 Jan 10;171(1):56-65).

Relevant information from the Primary Care Physician includes the patient’s history, diagnostic tests and results and reason for the consultation. The specialist is responsible for communicating
the results of the consultation and ongoing recommendations and treatment plans.

Information exchange between providers should be timely, relevant and accurate to facilitate ongoing patient management. The partnership between the Primary Care Physician and specialist is based on the consistent exchange of clinical information and this communication is a key factor in providing quality patient care.