

# PrimePartners

## for Case Managers

Volume 10, Issue 5  
June 2016

### In this issue:

- ▶ Elderly Waiver (EW) Customized Living (CL) and Adult Foster Care Services Rate and Billing Code Changes
- ▶ New to Our Website: CCM FAQs and Refused/Unresponsive Outreach Letter
- ▶ Formulary Changes and Refill Reminder Calls
- ▶ New Opioid Prescribing Guidelines from the Centers for Disease Control and Prevention (CDC)
- ▶ Barrier Analysis in Care Plan Development
- ▶ Minnesota's Air Quality
- ▶ Facts about Marijuana
- ▶ Post-Traumatic Stress Disorder (PTSD)
- ▶ Tools for Person-Centered Thinking: Part 4 of 7
- ▶ Important Dates
- ▶ Contact Information

## Elderly Waiver (EW) Customized Living (CL) and Adult Foster Care Services Rate and Billing Code Changes

*Kristi Shamp, RN, BSN, CPHM, SNP Senior Care/UM Care Coordinator*

The Minnesota Department of Human Services (DHS) Aging and Adult Services Division is changing the authorization and billing codes for Customized Living (CL) and adult foster care services under the Elderly Waiver (EW) program. Changes include moving to daily rather than monthly authorization and billing codes, using a daily rather than monthly rate, and changing billing practices to allow providers to bill only for the actual dates of service provided.

The code changes are as follows:

- CL monthly code T2030 is changing to daily code T2031
- 24-hour CL monthly code T2030 TG is changing to daily code T2031 TG
- Adult foster care (family) monthly code S5141 is changing to daily code S5140
- Adult foster care (corporate) monthly code S5141 HQ is changing to daily code S5140 U9

**PrimeWest Health will discontinue the monthly codes and rates effective June 30, 2016, and will begin using the daily codes and rates for dates of service on and after July 1, 2016.** We will revise service agreements to reflect the authorized daily rate and appropriate code, and providers will submit claims using the updated service agreement.

For more information about these changes, please see **DHS Bulletin #16-25-01**. If you have questions, send them to [seniorcare@primewest.org](mailto:seniorcare@primewest.org). 

## New to Our Website: CCM FAQs and Refused/Unresponsive Outreach Letter

*Elizabeth Warfield, RN, BSN, Senior Care Coordinator*

There are two new resources on the PrimeWest Health website. The first is a **Frequently Asked Questions (FAQ) page** just for PrimeWest Health county case managers! Please feel free to provide any feedback you have as well as any questions you would like to see included on the FAQ page by sending an email to [seniorcare@primewest.org](mailto:seniorcare@primewest.org) or [snbc.phc@primewest.org](mailto:snbc.phc@primewest.org). We will be updating the content periodically and hope this will be a helpful resource.

A new letter is also available on the website. The Refused/Unresponsive Outreach Letter is a follow-up letter to be used when PrimeWest Health county case managers or care coordinators are unable to complete initial/annual outreach by phone. This letter can be accessed on the **County Case Manager Forms** page by clicking on *Refused/Unresponsive Outreach Letter*. A pop-up box may appear asking if you want to open or save the document. Please select “Save as” and then fill in the necessary information. For program-specific guidelines about the appropriate number of attempts to contact the member by phone and when to use the letter, please refer to the Health Risk Assessment (HRA) process. If you would like a copy of the HRA process or have questions about it, please send a request to [seniorcare@primewest.org](mailto:seniorcare@primewest.org) or [snbc.phc@primewest.org](mailto:snbc.phc@primewest.org). 

## Formulary Changes and Refill Reminder Calls

*Ann Ehlert, PharmD, Pharmacy Manager*

### Medical Assistance/MinnesotaCare formulary changes

The following changes will be made to the Medical Assistance/MinnesotaCare formulary effective July 1, 2016:

- Suboxone® will be replaced by Bunavail® or Zubsolv®.
- Pataday® eye drops will be removed and replaced with a generic alternative.
- FreeStyle or Precision blood glucose test strips will be preferred. All other test strip brands will require a formulary exception.
- Generic Ortho Tri-Cyclen Lo® will be added.
- Rizatriptan ODT, the generic version of Maxalt-MLT®, will be added for migraine prevention. The other preferred migraine medication is sumatriptan, the generic version of Imitrex®.
- Enbrel® will be added.
- Propranolol ER will be added.

Lidocaine patches will be added to the Medical Assistance/MinnesotaCare formulary. They will *not* be covered for members who have Medicare, either with PrimeWest Health or elsewhere.

### Refill reminder calls

To help members with Medicare adhere to their prescribed medications, PrimeWest Health’s Pharmacy Benefit Manager (PBM), MedImpact, uses computer software to contact members with medication refill reminders. The software “reads” the member a script that has been approved by PrimeWest Health. As part of this process, members receiving a call have to confirm their identity by entering some information such as their birthday on the telephone keypad. The member is then told which medicine is due to be refilled and is prompted to enter a reason why the medication has not been filled. Members can opt out of these calls by contacting PrimeWest Health Member Services at **1-866-431-0801** (toll free). 

## New Opioid Prescribing Guidelines from the Centers for Disease Control and Prevention (CDC)

*Ann Ehlert, PharmD, Pharmacy Manager*

Opioids are a class of highly addictive pain medications that target opioid receptors in the brain to alleviate pain. Prescription opioids include oxycodone, fentanyl, ketamine, and hydrocodone. As a county case manager, you can work with members and providers to evaluate whether opioids are the right course of treatment.

In March 2016, the Centers for Disease Control and Prevention (CDC) released guidelines for prescribing opioids for chronic pain in the United States. These guidelines recommend non-pharmacologic therapy and non-opioid therapy as first-line treatments for pain, with certain exceptions, such as in cases of palliative care or cancer care, when opioids may be a first-line treatment (Dowell 2016).

If opioids *are* prescribed, members should set a realistic treatment plan with their prescriber. Many patients believe that the goal is zero pain, which may not be realistic. A more realistic goal might be *improved* pain relief or increased function (Dowell 2016). Additional CDC guidelines for the prescription of opioids are below.

## Formulation type

The CDC reviewed whether immediate-release opioid formulations (which patients take multiple times a day) were as safe as extended-release opioid formulations (which patients take 1 – 2 times a day). The CDC found no evidence that extended-release versions were safer. In fact, extended-release formulations were more associated with overdose. As a result, the CDC recommends that opioids should be started at the lowest dose using immediate-release formulations (Dowell 2016).

## Days' supply limits

Because of their addictive nature, the CDC recommends limiting the amount of opioids a patient can have. Specifically, the CDC recommends the following supply limits:

- Three days or less for acute pain
- A maximum of 3 – 7 days for surgery or trauma (Dowell 2016)

## Morphine equivalent limits

Opioids are compared with morphine equivalent doses (MED). This means the prescriber or pharmacist takes the individual doses of opioids the patient has been prescribed, uses a conversion chart to convert it to the amount of morphine that would give the same analgesic effect, and then adds the numbers together. The CDC recommends prescribers not go over a threshold of 90 MED. (Dowell 2016).

PrimeWest Health's current morphine equivalent dose limit is 120 MED. (To get an idea of what this number means, drugs like fentanyl 75 mcg or oxycodone ER 60 mg are over this limit without any other medications contributing to the MED limit.) Members need to get a prior authorization to go over this limit.

Limits are established because when opioids are used in too high of a dose, they can lead to overdose, respiratory depression, and death. Patients may think they need a higher dose because opioids can cause something called hyperalgesia, an abnormally heightened sensitivity to pain. When a person is taking opioids, small things, like stubbing a toe, can feel more painful than it would if the person wasn't taking opioids. Patients should be evaluated for this condition while undergoing treatment with opioids (Lee 2011).

When you work with members who have been prescribed opioids, please take the opportunity to help both the members and their providers consider whether opioids are the right course of treatment and whether prescribing a dose over 120 MED is really in the member's best interest.

**Sources:** Dowell, Deborah, Tamara M. Haegerich, and Roger Chou, "CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016," *MMWR Recommendations and Reports* 65, no. 1 (March 18, 2016), [www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm](http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm).

Lee, Marion, Sanford Silverman, Hans Hansen, Vikram Patel, and Laxmaiah Manchikanti, "A Comprehensive Review of Opioid-Induced Hyperalgesia," *Pain Physician*, 14 (2011), [www.painphysicianjournal.com/current/pdf?article=MTQ0Ng%3D%3D&journal=60](http://www.painphysicianjournal.com/current/pdf?article=MTQ0Ng%3D%3D&journal=60). 

## Barrier Analysis in Care Plan Development

*Kristi Shamp, RN, BSN, CPHM, SNP Senior Care/UM Care Coordinator*

When working with members to develop care plans and goals, it is important to consider the barriers they may face when attempting to comply with the plan and achieve goals. As part of a member's Interdisciplinary Care Team (ICT), county case managers should conduct a barrier analysis to identify and determine what barriers each member may face. A barrier analysis may include, but is not limited to, analysis of the following:

- Member's understanding of his condition and treatment
- Member's desire to participate in the care plan



- Member's belief that his participation will improve his health
- Member's financial or transportation limitations that may hinder participation in care
- Member's mental and physical capacity to participate in care

Common problems or barriers that can interfere with a member's goals or ability to follow the care plan include, but are not limited to, the following:

- Court order
- Inadequate support system
- Medical complications
- Noncompliance
- Safety concerns
- Transportation
- Cultural and spiritual beliefs
- Financial or insurance issues
- Visual impairment
- Hearing impairment
- Psychological impairment
- Cognitive impairment
- Limited language or literacy
- Lack of understanding of a condition or low health literacy
- Lack of motivation

A barrier analysis can be performed at the individual goal level or be applied to the care plan as a whole. The following are the three options for documenting the analysis within the electronic care plan:

1. Populating the "Interventions Goals" summary tab by choosing the applicable barriers (if any) from dropdown menus
2. Listing the barriers in the "Update Comments" section of a goal
3. Documenting the application of the barrier analysis for the care plan as a whole in the ICT tab meeting notes

Taking time to evaluate barriers can help members and providers work together to achieve optimal outcomes and ensure the member participates in his care as actively as possible. 

## Minnesota's Air Quality

*Leah Roell, RN, SNBC Care Coordinator*

Poor air quality can cause people to experience chest pain or discomfort, shortness of breath, wheezing, fatigue, and coughing (MDH 2016). Anyone can experience the effects of poor air quality. However people with heart and lung disease such as congestive heart failure, angina, Chronic Obstructive Pulmonary Disease (COPD), emphysema, or asthma may experience the effects sooner and at lower levels. Children are also more susceptible to the effects (Be Air Aware 2016). If you work with members who have heart and/or lung conditions or are otherwise sensitive to air quality, you can help them better protect themselves from adverse effects by learning how to monitor the air quality.

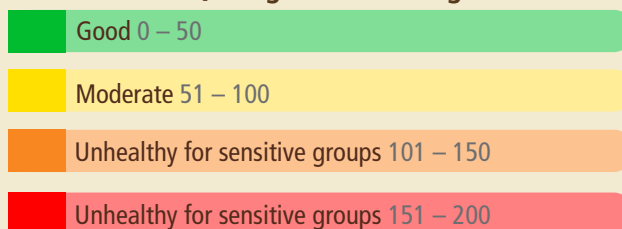
The Minnesota Department of Health (MDH) and the Minnesota Pollution Control Agency (MPCA) work together to monitor the air quality in Minnesota. According to the Be Air Aware website, measurements are taken at 50 different locations around the state and reported in the Air Quality Index (AQI), a real-time measurement of air quality conditions across the state established through hourly measurements of the following five pollutants:

- fine particles (PM2.5)
- ground-level ozone (O3)
- sulfur dioxide (SO2)
- nitrogen dioxide (NO2)
- carbon monoxide (CO) (MPCA 2016)

The higher the AQI, the lower the air quality. Encourage the members you see, especially those with heart and lung conditions, to monitor the AQI so they can schedule outdoor activities accordingly. The AQI can be found at [www.pca.state.mn.us/air/current-air-quality-index](http://www.pca.state.mn.us/air/current-air-quality-index).

Also let members know to pay attention to air pollution alerts, which are issued when the air quality has the potential to cause health concerns for people in the “moderate” and “sensitive groups.” The number shown is the AQI.

#### AQI range and meaning



**Good:** Current air quality is considered satisfactory and poses little or no health risk.

**Moderate:** Air quality is acceptable; however individuals who are very sensitive to air pollution may experience adverse health effects.

**Unhealthy for sensitive groups:** People with lung or heart disease, older adults, children, and people participating in activities that require heavy or extended exertion may experience adverse health effects.

**Unhealthy:** Everyone may begin to experience adverse health effects and members of sensitive groups may experience more serious health effects.

**Source:** MPCA, “Current Air Quality Index,” accessed June 7, 2016, [www.pca.state.mn.us/air/current-air-quality-index](http://www.pca.state.mn.us/air/current-air-quality-index)

As measured by MPCA, Minnesota’s overall air quality is good and has shown improvement over that last few years. However, poor air quality days and air pollution alerts are still something for members to consider when planning outdoor activities. County case managers can help members avoid exposure to outdoor pollutants by showing them where to find the air quality index and what it means.

**Sources:** Be Air Aware, “MPCA Air Monitoring,” accessed June 6, 2016, [www.beairawaremn.org/who-is-affected/monitoring](http://www.beairawaremn.org/who-is-affected/monitoring).

United States Environmental Protection Agency (EPA), “Fine Particle (PM2.5) Designations: Frequently Asked Questions, February 23, 2016, [www3.epa.gov/pmdesignations/faq.htm](http://www3.epa.gov/pmdesignations/faq.htm).

MDH, “Air Quality,” accessed June 6, 2016, [www.health.state.mn.us/topics/air/index.html](http://www.health.state.mn.us/topics/air/index.html).

MPCA, “Minnesota’s air quality,” accessed June 6, 2016, [www.pca.state.mn.us/air/minnesotas-air-quality](http://www.pca.state.mn.us/air/minnesotas-air-quality). 

## Facts about Marijuana

*Chelsey Wildman, BES, LADC, ADC-MN, Chemical Dependency Care Coordinator*

Medical marijuana is currently legal in several states, including Minnesota, and both medical and recreational marijuana are legal in a handful of states and cities (Wikipedia 2016). As more states legalize marijuana, either for recreational or medical use, many people do not realize it is still illegal everywhere under Federal law (SAMHSA 2015). In addition to the legal issues, it is important that people who use marijuana understand the adverse side effects it can have. As a county case manager, you can help educate members about the risks of marijuana use.

Given the media attention created when a state legalizes marijuana and the increasing acceptance of the substance, some may dismiss its potential dangers. It is important to recognize that delta-9-tetrahydrocannabinol (THC), the active ingredient in marijuana, is a “psychoactive (mind-altering) chemical.” According to the Substance Abuse and Mental Health Services Administration (SAMHSA):

The short-term effects of marijuana include problems with memory and learning, distorted perception, difficulty in thinking and problem-solving, and loss of coordination. The use of marijuana increases the risk of developing cancer of the head, neck, lungs, and respiratory tract due to toxins and carcinogens. Among youth, heavy cannabis use is associated with cognitive problems and increased risk of mental illness.

And among the elderly, the effects of marijuana can be misinterpreted as typical effects of aging, which may result in misdiagnosis (Perkinson 2012).

Marijuana can also interact with certain medications in the following ways:

- It may interfere with how the body processes certain medications. This can lead to the medication having a stronger effect than intended. It can also lead to a serious adverse reaction.
- It may increase drowsiness caused by certain medications such as benzodiazepines, barbiturates, narcotics, and some antidepressants.
- It may increase the risk of bleeding when taken with medications such as blood thinners that already cause an increased risk for bleeding.
- It may affect blood sugar levels, which can lead to problems for someone taking other medications that affect blood sugar, such as insulin (Mayo Clinic 2013).

When you talk with members who may be considering marijuana use, take the time to discuss these facts with them so they understand the risks. If you have questions, please contact **Chelsey Wildman**.

**Sources:** Mayo Clinic, “Marijuana (Cannabis sativa),” 2016, [www.mayoclinic.org/drugs-supplements/marijuana/background/hrb-20059701](http://www.mayoclinic.org/drugs-supplements/marijuana/background/hrb-20059701).

Perkinson, Robert R., *Chemical Dependency Counseling: A Practical Guide*. 4<sup>th</sup> ed. (Los Angeles: SAGE, 2012), 187.

SAMHSA, “Cannabis,” October 27, 2015, [www.samhsa.gov/atod/cannabis](http://www.samhsa.gov/atod/cannabis).

Wikipedia, “Legality of Cannabis by U.S. Jurisdiction,” May 19, 2016, [https://en.wikipedia.org/wiki/Legality\\_of\\_cannabis\\_by\\_U.S.\\_jurisdiction](https://en.wikipedia.org/wiki/Legality_of_cannabis_by_U.S._jurisdiction). 

## Post-Traumatic Stress Disorder (PTSD)

*Rachel Mead, RN, BS, CPHM, SNP Senior Care/UM Coordinator*

Did you know that June 27 is National Post-Traumatic Stress Disorder (PTSD) Awareness Day? If you work with members you believe suffer from PTSD, let them know that treatment is available and recommend that they make an appointment with their health care provider.

According to the Mayo Clinic, PTSD “is a mental health condition that’s triggered by a terrifying event—either experiencing it or witnessing it.” It’s something we commonly associate with veterans, but it can affect anyone at any age. PTSD affects a person’s entire life, including relationships, physical and mental health, and the ability to work. Someone diagnosed with PTSD can be at an increased risk for eating disorders, issues with drugs or alcohol, and depression or anxiety.

The symptoms of PTSD may change over time and are categorized into the following four groups:

- Intrusive memories
  - Symptoms include recurring, unwanted, and upsetting memories and/or dreams; severe reactions to “triggers” that recall the event; and flashbacks (reliving the event).
- Avoidance
  - Symptoms include avoiding—or trying to avoid—talking about the event or things that remind the person of the event.
- Negative changes in thinking and mood
  - Symptoms may include loss of interest in activities and feelings of hopelessness. Relationships may be affected and the person may think negatively about herself, others, and the future.
- Changes in emotional reactions (also called “arousal” symptoms)
  - Symptoms include feeling irritable, easily startled, on guard, or ashamed, as well as having outbursts and trouble sleeping or concentrating.



Psychotherapy (“talk therapy”) with or without medication is the main treatment for PTSD. Psychotherapy includes cognitive therapy (helping a person recognize the way she thinks), exposure therapy (helping a person directly face her fears and learn to cope with them), and eye movement desensitization and reprocessing (EMDR) (exposure therapy combined with guided eye movements). Commonly used medications include antidepressants, anti-anxiety medications, and a medication that may work to suppress nightmares.

If you work with someone who may have PTSD, talk to her about the availability of these treatments and encourage her to schedule a health care appointment to be assessed. Before the member goes to her appointment, have her write down all of her symptoms and the events and timeline that precede the onset of symptoms.

If self-harm is a concern, give the member the number for the National Suicide Prevention Lifeline, **1-800-273-8255** (toll free). Veterans can press “1” after dialing to reach the Veterans Crisis Line. And, **any time** you feel that someone is suicidal, call **911** or take the person to the nearest emergency room.

If you have questions about whether a medication for PTSD is covered by PrimeWest Health, please contact **Ann Ehlert**. If you have questions about covered services, you or the member can call PrimeWest Health Member Services at **1-866-431-0801** (toll free).

**Source:** “Post-Traumatic Stress Disorder (PTSD),” Mayo Clinic, April 15, 2014, [www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/basics/definition/con-20022540?p=1](http://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/basics/definition/con-20022540?p=1). 

## Tools for Person-Centered Thinking: Part 4 of 7

*Ann Tesch, RN, BSN, PHN, CCP, Complex Care Coordinator*

This is the fourth in a series of articles about tools to help county case managers develop a skill set focused on person-centered thinking, a concept that emphasizes empowerment, personal rights, choice, and inclusivity when working with members. This article focuses on the concept of routines.

Think about your day-to-day activities. Are you someone who has a cup of coffee every morning? Do you go to bed at the same time every night? Do you have to watch the news before going to bed or watch it first thing in the morning?

These are examples of routines. Other examples include how you celebrate birthdays, what you do when you feel sick, your spiritual practices, and how you acknowledge and recognize grief and loss. Whether we realize it or not, routines are important to us (if you’re a coffee drinker, think about what happens if you aren’t able to get that morning cup!). They contribute to our sense of comfort and control, providing consistency in our day-to-day lives. Routines are just as important to the people we support as they are to us.

Discovering a person’s routine is a valuable person-centered thinking skill. When taking into consideration what is important to an individual, include the person’s routines. For example, let’s say Jon is living in a group home and is expected to be ready for work by 8 a.m. However, once Jon is up, it is extremely difficult for Jon to get dressed, eat breakfast, and be out the door on time. Staff person Maria talks with Jon about the importance of being on time for work and asks Jon how staff can help him with his morning routine so he can get to work on time. Maria asks Jon what, for him, makes a morning “good.” Jon tells her, “It is a really good morning when I can hit snooze on my alarm clock three times before having to get out of bed.” The conversation continues, and Jon tells Maria that he needs the alarm clock to go off three times to give him time to “wake up and think” about what he needs to do for the day. Maria shares this information with house staff. The next day, Jon’s alarm is set to go off early enough to allow him to hit snooze three times before he needs to start getting ready for work. After making this change to accommodate his preferred routine, Jon is ready to go to work on time.

This is an example of finding out what is important to a person and how this affects his response to daily life. It involves taking the time to find out what someone's daily routine is and why it is important. Doing what you can to bring consistency to the person's life will also bring control and comfort, all things that empower the person being cared for.

For additional information, please contact **Ann Tesch**.

## Important Dates

### ✓ County supervisor meeting

Meetings are held on the third Thursday of the month, 10 a.m. – 3 p.m., at PrimeWest Health in Alexandria, unless otherwise noted.

|              |             |
|--------------|-------------|
| July 21      | October 20  |
| August 18    | November 17 |
| September 15 | December 15 |

### ✓ County case management educational training

Trainings are held on the fourth Wednesday of the month via webinar from 10 a.m. – noon, unless otherwise noted.

|              |             |
|--------------|-------------|
| June 22      | October 26  |
| July 27      | November 23 |
| August 24    | December 28 |
| September 28 |             |

## Contact Information

**Ann Ehlert, PharmD, Pharmacy Manager**

1-320-335-5207 or 1-888-588-4420 ext. 5207 (toll free)

[ann.ehlert@primewest.org](mailto:ann.ehlert@primewest.org)

**Ann Tesch, RN, BSN, PHN, CCP, Complex Care Coordinator**

1-320-335-5287 or 1-888-588-4420 ext. 5287 (toll free)

[ann.tesch@primewest.org](mailto:ann.tesch@primewest.org)

**Chelsey Wildman, BES, LADC, ADC-MN, Chemical Dependency Care Coordinator**

1-320-335-5267 or 1-888-588-4420 ext. 5267 (toll free)

[chelsey.wildman@primewest.org](mailto:chelsey.wildman@primewest.org)

You can find a PDF copy of *PrimePartners* by going to our website. Go to [www.primewest.org/primepartners](http://www.primewest.org/primepartners).