



Provider Connection

Obesity, Weight Gain in Middle Age Associated With Increased Risk of Diabetes Among Older Adults

For individuals 65 years of age and older, obesity, excess body fat around the waist and gaining weight after the age of 50 are associated with an increased risk of diabetes, according to a study in the June 23/30 issue of *JAMA*.

The incidence of diabetes in the United States has doubled in the past 15 years, and is highest among adults 65 to 79 years of age. Approximately 70 percent of U.S. men and women 60 years of age and older are overweight or obese [BMI -- body mass index 25 or greater]. Adiposity [body fat] is a well-recognized risk factor for type 2 diabetes among young and middle-aged adults, however, the relationships between different measures of body composition and diabetes in older adults [65 years of age or older] are not well described.

The researchers examined the relationship between measures of overall body fat, fat distribution, changes in these measures, and diabetes risk among 4,193 men and women 65 years of age and older. Measures of adiposity were determined when participants entered the study, and repeated 3 years later. The incidence of diabetes was ascertained based on use of antidiabetic medication or a fasting blood glucose level of 126 mg/dL or greater.

Over a median (midpoint) follow-up of 12.4 years, 339 new cases of diabetes were diagnosed among the study participants. The researchers found that BMI at baseline, BMI at 50 years of age, weight, fat mass, waist circumference, waist-hip ratio, and waist-height ratio were all strongly related to the risk of diabetes. For each measure, there was a graded increase in the risk of diabetes with increasing quintiles of adiposity. Participants in the highest category of adiposity had an approximately 2- to 6-fold increased risk of developing diabetes compared with those in the lowest category. The researchers found no evidence of significant statistical interaction by sex or race.

Also, compared with participants whose weight remained stable (plus or minus 4.4 lbs.) over the time period, those who gained 20 lbs. or more between the age of 50 years and study entry had an approximately 3-fold greater risk of developing diabetes during follow-up, regardless of their BMI at 50 years of age. Participants who were obese (BMI 30 or greater) at 50 years of age and who experienced the most weight gain (more than 20 lbs.) between the age of 50 years and study entry had 5 times the risk of developing diabetes compared with weight-stable participants with normal BMI (less than 25) at 50 years of age.

The researchers also found that participants in the highest categories of both BMI and waist circumference had more than 4 times the risk of those in the lowest category of both measures. Participants with a greater than 4 inch increase in waist size from baseline to the third follow-up visit had a 70 percent higher risk of type 2 diabetes compared with those who gained or lost 0.8 inches or less.

Results of this study affirm the importance of maintaining optimal weight during middle age for prevention of diabetes and, while requiring confirmation, suggest that weight control remains important in reducing diabetes risk among adults 65 years of age and older.

Mary L. Biggs; Kenneth J. Mukamal; Jose A. Luchsinger; Joachim H. Ix; Mercedes R. Carnethon; Anne B. Newman; Ian H. de Boer; Elsa S. Strotmeyer; Dariush Mozaffarian; David S. Siscovick. **Association Between Adiposity in Midlife and Older Age and Risk of Diabetes in Older Adults.** *JAMA*, 2010; 303 (24): 2504-2512

Behavioral Health Provider Update

Psychcare is Total Health Care's behavioral health provider. Psychcare's website contains important information that is beneficial to practitioners and providers. See the 2009 3rd Quarter Network Practitioner/Provider Website Notification insert for more information.

INSIDE THIS ISSUE:	Page
Advance Directives	3
Behavioral Health Provider Update	1
Diabetes Risk	1
Immunization Schedules	2
Member Rights & Responsibilities	4
Need to Contact Us!	4
Pharmacy News!	3
Psychcare Website Notification	Insert
Utilization Management Process	4

IMMUNIZATION UPDATES

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2010

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			HepB				
Rotavirus ²				RV	RV	RV ²						
Diphtheria, Tetanus, Pertussis ³				DTaP	DTaP	DTaP	^{see footnote³}	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 footnote⁸}	MMR	
Varicella ⁹								Varicella		^{see footnote⁹}	Varicella	
Hepatitis A ¹⁰								HepA (2 doses)			HepA Series	
Meningococcal ¹¹											MCV	

Range of recommended ages for all children except certain high-risk groups

Range of recommended ages for certain high-risk groups

Recommended Immunization Schedule for Persons Aged 7 Through 18 Years—United States • 2010

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
Human Papillomavirus ²		^{see footnote 2}	HPV (3 doses)	HPV series
Meningococcal ³		MCV	MCV	MCV
Influenza ⁴		Influenza (Yearly)		
Pneumococcal ⁵		PPSV		
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		

Range of recommended ages for all children except certain high-risk groups

Range of recommended ages for catch-up immunization

Range of recommended ages for certain high-risk groups

Figure 2. Vaccines that might be indicated for adults based on medical and other indications

INDICATION ►	Pregnancy	Immuno-compromising conditions (excluding human immunodeficiency virus [HIV]) ^{1,2,3}	HIV infection ^{4,5,6,7} CD4+ T lymphocyte count <200 cells/µL >200 cells/µL	Diabetes, heart disease, chronic lung disease, chronic alcoholism	Asplenia ⁸ (including elective splenectomy and persistent complement component deficiencies)	Chronic liver disease	Kidney failure, end-stage renal disease, receipt of hemodialysis	Health-care personnel
Tetanus, diphtheria, pertussis (Td/Tdap) ^{1,2}	Td	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs						
Human papillomavirus (HPV) ^{2,3}		3 doses for females through age 26 yrs						
Varicella ^{4,5}	Contraindicated							2 doses
Zoster ⁶	Contraindicated							1 dose
Measles, mumps, rubella (MMR) ^{7,8}	Contraindicated							1 or 2 doses
Influenza ⁹								1 dose TIV annually
Pneumococcal (polysaccharide) ¹⁰								1 or 2 doses
Hepatitis A ¹¹								2 doses
Hepatitis B ¹²								3 doses
Meningococcal ¹³								1 or more doses

¹Covered by the Vaccine Injury Compensation Program. ²For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection) ³Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications) ⁴No recommendation

These schedules indicate the recommended age groups and medical indications for which administration of currently licensed vaccines is commonly indicated for adults ages 19 years and older, as of January 1, 2010. Licensed combination vaccines may be used wherever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are issued during the year, consult the manufacturers' package inserts and the complete statements from the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/pubs/acip-list.htm).

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Physicians (ACP).



Therapeutic Drug Class Review Updates (Medicaid and Commercial)



THC's Pharmacy & Therapeutic Committee met in June 2010 and made the following drug updates:

Angiotensin Receptor Blockers (ARB) Drug Class

Cozaar (losartan) & **Hyzaar** (losartan/hydrochlorothiazide) will be the preferred covered drugs. Benicar/HCT and Micardis/HCT will no longer be formulary drugs with THC. (Medicaid will continue to require current Step Therapy of trial and failure of an ACE inhibitor prior to payment of the preferred ARBs).

Inhaled Corticosteroid (ICS) Drug Class

THC will be moving to a single preferred inhaler in the Inhaled Corticosteroid (ICS) therapy class. The **preferred inhaler will be QVAR[®]** (beclomethasone dipropionate HFA) inhaler. Asmanex Twisthaler[®] (mometasone furoate), and Pulmicort Flexhaler[™] (budesonide) will no longer be formulary drugs with THC.

QVAR[®] is available as both a 40 mcg and 80 mcg 7.3 gram canister that delivers 100 metered inhalations. QVAR[®] dosing can be given in 1 puff or up to 2 puffs twice a day.

Triptan Drug Class Review

Imitrex tablets (sumatriptan) will be the preferred triptan agent. Maxalt/MLT, Relpax, Zomig/ZMT, & Axert will no longer be formulary drugs with THC. Actoplus Met quantity limits will be updated to a daily dose limit of 2.

Keppra (levetiracetam) tablets and oral solution will be added to the commercial formulary with quantity limits.

Drug Prior Authorization Criteria

Prior Authorization Criteria for prescription drug is available upon request to the Pharmacy Department for THC's Providers. If you would like a copy of specific drug criteria you may request it in writing or you may call the Pharmacy Department.

Pharmaceutical Management Procedures

Please note that THC's formularies have been updated and are on our web site at www.totalhealthcareonline.com for your review.

Visit THC's web site to view the Condensed and Expanded Drug Formularies for Commercial and Medicaid Members. Listed under the Condensed formularies are THC's pharmaceutical management procedures to include generic substitution, step therapy, quantity limits, and prior authorization request. If you would like a copy of the formularies or pharmaceutical management procedures, you may call the Pharmacy Department at 313-871-2000, and press 9.

If you should have any pharmacy questions, please feel free to call us at 313-871-2000, option 9.

ADVANCE DIRECTIVES

As a primary care provider for Total Health Care, you are asked to encourage members as appropriate to develop Advanced Directives and maintain a copy of such in their medical record. While it is not mandatory for all members to have such a document, there are situations where it may be appropriate for the member and his/her family to consider developing a plan, should there be a need to make decisions in a crisis situation. Total Health Care encourages its members to take responsibility for their medical treatments and to participate in decision-making. As the primary care physician, you should assist them in this process. Each member receives a copy of a Special Edition Member Newsletter at enrollment that outlines the Patient Self Determination Act and explains how to establish a patient advocate designation and make decisions about treatments. Contact the Provider Relations Department for any information on advanced directives at (313) 871-7809.



Member Rights and Responsibilities*

Members have the right...

- ◇ To get information about Total Health Care, its services, its providers and member rights and responsibilities.
- ◇ To make recommendations regarding Total Health Care's member rights and responsibilities policy.
- ◇ To receive quality health care.
- ◇ To be treated with respect and dignity by others.
- ◇ To have privacy while you receive care.
- ◇ To have your personal and health records kept confidential.
- ◇ To take part with your doctors in decision making about your health care.
- ◇ To talk openly about your treatment options regardless of cost or benefit coverage. You have a right to get these explained in words that you understand.
- ◇ To tell Total Health Care in advance how you wish to be treated if you ever become too ill to decide for yourself. This is your legal right.
- ◇ To request information about how Total Health Care pays your doctor, call Total Health Care's Member Services Department.
- ◇ To voice your complaints or appeals about Total Health Care or the care provided. To voice your concerns about the service or care you receive, call the Member Services Department at (313) 871-2000 or toll-free at (800) 826-2862 and tell us. Our offices are open every day, Monday through Friday 8:30 am until 5:00 pm.

*Total Health Care's staff and providers will comply with all regulations concerning your rights.

Members have the responsibility...

- ◇ To get all your health care services through Total Health Care.
- ◇ To know how the plan works and how to follow the rules.
- ◇ To make appointments for routine care, keep appointments and be on time. Call before the appointment, if you need to cancel.
- ◇ To provide Total Health Care and its providers with the information needed to care for you. To tell the truth about any changes in your health.
- ◇ To listen and follow your doctor's advice.
- ◇ To help your doctor decide what treatment will work best for you.
- ◇ To follow the plans and instructions for care that you have agreed to with your doctor.
- ◇ To know the names of your medicines. To know what they are for and how to use them.
- ◇ To always carry your Total Health Care ID card to receive services.
- ◇ To respect the rights of other patients, doctors and staff of Total Health Care.
- ◇ To tell Total Health Care if you move or change telephone numbers. To tell Total Health Care about any changes that will change your health benefits (like marriage, divorce, childbirth, change of address, or death).

**distributed to members annually*

Utilization Management Process

It is the policy of Total Health Care to utilize written, accepted criteria for use in decision-making in all utilization management processes. Utilization Management (UM) uses InterQual criteria for hospital admissions and continued stay reviews in decisions to determine medical necessity. UM uses objective, evidenced-based, nationally established and acceptable criteria in determining medical services decisions to determine medical necessity. All criteria used are available to providers and members upon request. The criteria can be obtained by contacting a UM Specialist at 313-871-2000 or 1-800-826-2862, option 4.

UM staff is available to answer any questions providers may have or assist providers that are seeking information about the UM process or the authorization of care. UM staff is available to take your incoming calls eight hours a day during normal business

hours. Incoming requests for UM staff after normal business hours can be left on the UM Coordinator's voicemail. Return calls regarding UM inquiries are completed during normal business hours. Members of the UM staff identify themselves by name, title and organization when initiating or returning calls regarding UM issues.

Providers can discuss any UM denial decision, non-behavioral health or behavioral health, with a board certified physician, practitioner or other appropriate reviewer. The doctor who requested the care may speak to a physician regarding this decision by calling Total Health Care at 313-871-7875. All UM decisions are based only on the existence of coverage and appropriateness of care and service. Total Health Care does not specifically reward practitioners or any other individuals for denying covered services or care. UM decision makers do not receive financial incentives that may encourage decisions, which may result in underutilization.

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PRACTITIONER / PROVIDER WEBSITE NOTIFICATION

Dear Psychcare Network Practitioner/Provider:

We encourage you and your patients to visit our website, www.psychcare.com. The website contains information about current UM, Provider Relations, and claims processes as well as educational information to share with your patients. Information collected on the Psychcare website is for quality improvement, utilization management, credentialing and recredentialing, and network practitioner purposes. The confidentiality of the information collected is maintained as per HIPAA requirements. The website includes, but is not limited to:

Quality and services activities:

- How to obtain information about our 2010 Quality Improvement Program, and a report on the progress in meeting our goals
- Psychcare Privacy Practices
- Practice-site treatment record confidentiality standards
- Provider treatment record confidentiality standards (**Updated**)
- Outpatient Treatment Record Confidentiality and Documentation Standards
- AHCA Requirements for Florida Medicaid Outpatient Treatment Record Documentation and Aggregate 2009 Results
- Links to national and community resources, such as 12-step Programs, community support groups, HIPAA, and the FDA

Clinical quality activities:

- Psychcare Clinical Management Guideline Compendium
- Members' Rights and Responsibilities and Member Literature
- Antidepressant Medication Management Initiatives (**Updated**)
- Atypical Antipsychotic Medication Management Initiatives

Continuity and coordination of care activities:

- Continuity and coordination of care activities among behavioral healthcare specialists and between behavioral healthcare specialists PCPs
- High Risk Criteria to enhance communication between practitioners and providers
- Psychcare Network Behavioral Specialist Healthcare Notification Form
- The Psychcare Client Primary Care Physician Notification Form
- The Annual Client Primary Care Physician Manual and Manual Satisfaction Survey
- 7 and 30 day ambulatory follow-up after an inpatient hospitalization processes (**Updated**)
- Inpatient psychiatric consultation timeliness standards
- PharmAssist© Program

Utilization Management activities:

- Psychcare Mental Health Level of Care Clinical Criteria (**Updated**)
- Psychcare Substance Abuse Level of Care Clinical Criteria
- Psychcare Medicaid Level of Care Guidelines
- Accessibility to Customer Service Staff and Clinical Staff to discuss utilization management issues
- Ensuring appropriate utilization management
- Conflict of Interest Statement
- Pre-service, concurrent, and post-service review decision-making timeliness standards
- Inpatient authorization processes



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PRACTITIONER / PROVIDER WEBSITE NOTIFICATION

- Outpatient authorization processes
- Post-service review processes for Psychcare network practitioners and providers
- The opportunity to request a Peer Clinical Review to discuss an initial medical necessity denial determination

Preventive Health activities:

- 2010 Prevention Program Outcomes Survey
- Adolescent Suicide Prevention Program and Stakeholder Comment Form
- Alzheimer's Disease Preventive Health Program and Stakeholder Comment Form
- Substance Abuse Prevention Program and Stakeholder Comment Form
- Childhood ADHD Preventive Health Program and Stakeholder Comment Form
- Postpartum Depression Prevention Program and Stakeholder Comment Form
- Stress Management Prevention Program and Stakeholder Comment Form
- Domestic Violence Prevention Program and Stakeholder Comment Form
- Eating Disorders Prevention Program and Stakeholder Comment Form
- Tobacco Cessation

Most of the information on the website can be downloaded. If you would like a hard copy of the any of the documents and/or activities we have on our website, please call our Quality Management Department at (800) 221-5487, Monday through Friday, 8:30 AM to 5:30 PM. We have also enclosed the Psychcare Website Member Notifications. We ask that you distribute the applicable notification to your Psychcare patients so they can also access our website to assist in self-management of their illness.

Thank you