the checkup

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ZIKA ALERT: Texas Medicaid Announces Mosquito Repellent Update

The Texas Medicaid Director has issued an update to the original decision to require a prescription for mosquito repellents in order for them to be covered as a pharmacy benefit for Texas Medicaid and CHIP recipients.

To aid in the prevention of the Zika virus, mosquito repellent products were added to the Texas Medicaid and CHIP formularies on August 9, 2016 and required a prescription from a health care provider. However, effective August 15, 2016 a Texas Medicaid Standing Order for Mosquito Repellent was issued and allows eligible participants in Medicaid and CHIP to obtain mosquito repellent without a prescription.

Visit http://tchpenterprisestg.prod.acquia-sites.com/for-providers for complete details.

In this ISSUE

Texas Children's Health Plan

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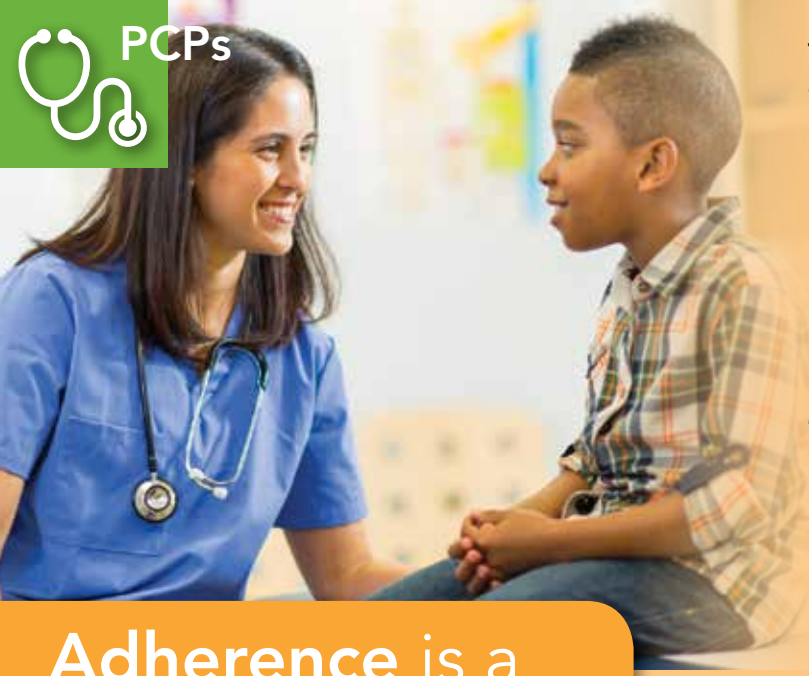


Adherence is a key to success in chronic care

There are 5 simple strategies to improve medication adherence:

1) Engage the patient. Show non-verbal attentiveness. Give non-verbal encouragement. Give verbal praise for things done well.

2) Acknowledge non-adherence as normal. Taking medicine when you feel well is not something a "normal" person does.

3) Find out the patient's underlying concerns or worries about the medications.

4) Review role of medications, goals of therapy, and jointly negotiate a treatment plan. Tailor the medication schedule to the patient's routines.

5) Help the patient develop a concrete plan for routines for taking medication such as:
- Before brushing teeth
- Program alarm into cell phone
- Before playing video games

The routine that works best for the patient may be different from what would work for you. Your patient will know their routines and what can work best for them.

Harold J. Farber, MD, MSPH, Associate Professor of Pediatrics
Baylor College of Medicine and Texas Children's Hospital
Associate Medical Director, Texas Children's Health Plan

November CME:
What Goes Up Must Come Down

Thursday, November 10, 2016
6-8 p.m.
Go to www.TexasChildrensHealthPlan.org/CME for further details.

Undescended testicles and the use of ultrasound

Cryptorchidism or undescended testis (UDT) is the most common urological birth defect, occurring in 1 in 33 live male births. The most important reasons for surgical treatment of cryptorchidism include increased risks of testicular malignancy, infertility, testis torsion and/or inguinal hernia. The current standard of treatment for any UDT that fails to spontaneously descend by 6 months of age in the United States is orchidopexy (surgery to reposition the testis to the scrotum). Evaluation of UDT includes a thorough gestational history and a physical exam with a particular focus on noting the quality and position of the testes.

Neither the American Academy of Pediatrics (AAP) or the American Urologic Association (AUA) recommend the use of ultrasound (US) or any other imaging modalities for evaluation of cryptorchidism. Indeed, both suggest not obtaining imaging for UDT.

There are multiple factors that influence this recommendation, including accuracy of imaging, cost, availability of certain imaging modalities, rate of false positive, and need for anesthesia (for CT and MRI). While US is inexpensive, widely available, and does not require anesthesia, it is non-contributory in its routine use due to a low sensitivity (45%) and specificity (78%) in localizing the non-palpable testis. A prepubertal intraabdominal testis is typically not detected by US and maybe mistaken for a lymph node, which is similar in sonographic appearance. The ionizing radiation exposure and high costs associated with CT scan preclude its use. While MRI has a higher sensitivity and specificity for detection of intraabdominal testis, its use is deterred by high cost, limited availability and need for general anesthesia. Currently, no radiological test can be used to definitively conclude that a testis is absent.

Hence, surgery in the form of diagnostic laparoscopy or open exploration is required for all non-palpable unilateral and many bilateral UDT patients. Accordingly, regardless of preoperative radiologic findings, these studies rarely assist in clinical decision making and may lead to misleading information (such as absence when actually present or vice versa).

Primary Care Providers who are concerned about a potential diagnosis of undescended testicle should consider referral to urology or surgery for further evaluation.

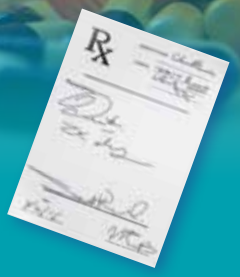
Abhishek Seth, MD, Assistant Professor, Urology and Pediatrics, Baylor College of Medicine

Sources: Kolon TF, Herndon A, Baker LA, Baskin LS, Baxter CG, Cheng EY, Diaz M, Lee PA, Seashore CJ, Tasian G, Barthold J. "Evaluation and Treatment of Cryptorchidism: AUA Guideline" www.auanet.org

Changes to the **Sterilization Consent Form,** Instructions, Approval Process, and Denial Letter

Information posted July 15, 2016

Effective September 1, 2016, changes will be made to the Sterilization Consent Form and corresponding instructions, the Sterilization Consent Form Denial Letter, and the process that providers must follow to submit the consent form to TMHP. **For a list of the changes, go to TheCheckup.org.**



Appropriate use of opiates for pain management

Not too much and not too long

In March 2016, the US Centers for Disease Control and Prevention (CDC) released a guideline for prescribing opioids for chronic pain. The most important points for primary care providers treating acute pain severe enough to require opioids are to prescribe the **lowest effective dose of immediate-release opioids** and to prescribe **a quantity no greater than what is necessary. Three days or less will often be sufficient;** more than seven days will rarely be needed.

Opioid pain medication use presents serious risks, including overdose and opioid use disorder. From 1999 to 2014, more than 165,000 persons died from overdose related to opioid pain medication in the United States. The CDC guideline is intended to apply to patients aged ≥18 years with chronic pain outside of palliative and end-of-life care. Key points from the guideline are as follows:

Determining When to Initiate or Continue Opioids for Chronic Pain
Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation
When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids. When opioids are started, clinicians should prescribe the lowest effective dosage. Long-term opioid use often begins with treatment of acute pain.

When opioids are used for **acute pain,** clinicians should **prescribe the lowest effective dose** of immediate-release opioids and should prescribe **no greater quantity than needed** for the expected duration of pain severe enough to require opioids. **Three days or less will often be sufficient;** more than seven days will rarely be needed.

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently.

Assessing Risk and Addressing Harms of Opioid Use
Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65:1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1

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COMING SOON TO YOUR TCHP PROVIDER PORTAL:

Vision Population Management

Help your office comply with HEDIS measures

You can help your doctor be successful with HEDIS measures! Vision is the Population Management, web-based application that provides claims and HEDIS measure data to PCPs for members who are assigned to their panel or whom they have had a treating relationship with.

The Vision application allows PCPs access to their full eligible member list for the following Well Child Measures:

- Adolescent Well-Care Visits
- Well-Child Visits in the First 15 Months of Life: 0-6 Visits
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

PCPs can access the list anytime to review their compliant and non-compliant members. The list is refreshed by the 15th of each month. PCPs will know which patient to outreach to for the well child exams and improve your HEDIS scores. Patient contact information stays more current since it is linked to the member portal.

Additional benefits include:

- Direct access to patient's health information for pharmacy, lab results, ER and urgent care visits, inpatient stays, and care plans
- Recommended care items for patients display within the patient's summary to help PCPs track which services the patient will need at the point-of-service
- The recommended care page lists: care items the patient will need, estimated due dates for care items, and status of care items

Vision help and training link:
https://products.valencesolutions.com/modules/Vision/static/com/valencehealth/VisionHelp/index.html

For additional questions please contact your Provider Relations Manager.

For further reading

You can go to our website and log-in to **Provider TouCHPoint** to learn more on topics like:

- **Quality program goals, processes, and outcomes**
- **Referrals to case management**
- **Pharmaceutical management procedures**
- **Disease Management Programs**
- **Formulary**
- **How practitioners can access authorization criteria**
- **Limits/quotas**
- **Availability of staff to discuss authorization process**
- **Supporting an exception process**
- **Availability of TDD/TTY services**
- **Member rights and responsibilities**
- **Availability of language assistance for members**
- **Generic substitution, therapeutic interchange, and step therapy protocol**
- **Prohibiting financial incentives for utilization management decision makers**
- **Clinical practice guidelines and preventive health guidelines**

STAR Kids Provider Training Schedule **coming soon!**

Beginning September 1, 2016, STAR Kids Provider Training will be offered in multiple locations, including the Harris, Jefferson and North East Medicaid service areas. **Make your plans today to attend a training near you. Check our website for training details.**

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