

# PROVIDER

## Newsletter

## PROVIDER SELF-SERVICE OPTIONS

### GUIDE TO ACCESSING OUR SERVICES

WellCare is proud to offer our providers several self-service options. By having valuable information and features available online and via our newly enhanced interactive voice response (IVR) system, you are able to conduct transactions when it is convenient for you. The user-friendly solutions give you immediate access to pertinent information regarding member eligibility, your submitted claims, authorization requests and more.

#### OPTION 1 – WELLCARE'S WEB SITE

Visit our Web site at [www.wellcare.com](http://www.wellcare.com).

Once you become a registered user of the provider portal, you can verify eligibility, check claims status and receive updates on authorization requests. If you still have questions, you can submit an e-mail form under the "Contact Us" option.

Members can also use the Web site for information such as submitting questions, requesting changes of information, printing temporary ID cards and much more.

#### OPTION 2 – AVAILITY'S WEB SITE

Register for free on Availity's Web site at [www.availity.com](http://www.availity.com) to access real-time HIPAA 276/277 Claim Status Electronic transactions and HIPAA 270 Eligibility Request and 271 Payer Response transactions. You can check member eligibility and claim status information for all of the health plans partnered with Availity. Increased functionality will be coming in the future.

#### OPTION 3 – IVR

Call our WellCare automated IVR telephone system. This toll-free number can be found at the top of your WellCare **Quick Reference Guides**. Use the IVR system to check the status of authorizations and claims or verify eligibility. You can also obtain a list of participating providers or pharmacies.

You may also speak with a Customer Service representative by calling the toll-free number listed at the top of your **Quick Reference Guide** if you are unable to find answers on the Web or through the IVR system.

If you still need assistance, contact your local Provider Relations representative. Your representative can help with questions regarding contracts, credentialing/configuration and persistent claims/authorization issues.

## PROVIDER MATERIALS UPDATE

The following correspondence was sent to providers via fax or was posted on WellCare's provider portal Messages area after our last newsletter published:

- New York's Fall Provider Newsletter
- H1N1 Vaccination Update
- Mammography Guidelines
- Fraud, Waste and Abuse Training
- Check Claims Status Now in Real Time

After you log in to the provider portal on [www.wellcare.com](http://www.wellcare.com), click on the *Provider* tab and you will see *Messages from WellCare* located in the right-hand column. Remember to check the messages regularly for new and updated information.

#### PROVIDER SERVICES IVR SYSTEM

As a reminder, when you require information relating to WellCare, please dial Provider Services at 1-800-278-5155 for Medicare and push prompt #5. Dial 1-800-288-5441 for Medicaid and prompt #3 will take you to the provider menu.

When you use the correct phone number and select the correct prompts, you eliminate the need to be transferred to a different department. This will save valuable time for you and your staff.

#### WEB RESOURCES

WellCare's Preventive and Clinical Practice Guidelines, Quick Reference Guide, Pharmacy Guidelines, Cultural Competency Plan and other helpful resources are available at [www.wellcare.com/provider/resources](http://www.wellcare.com/provider/resources).



## DIABETES AND THE A1C TEST

The A1c test (also known as HbA1c, glycated hemoglobin or glycosylated hemoglobin) is an essential measure for diabetes care. While conventional home glucose monitoring measures a patient's blood sugar at a given moment, the A1c test indicates a patient's average blood glucose level over the past few months.

### UNDERSTANDING A1C NUMBERS

For a patient without diabetes, a typical A1c level is about 5 percent. For someone with diabetes, the American Diabetes Association (ADA) recommends an A1c target of less than or equal to 7 percent. The American Association of Clinical Endocrinologists recommends a level of 6.5 percent or below.

The ADA also emphasizes that A1c goals should be individualized. The National Institutes of Health (NIH) says that, in general, every percentage point drop in an A1c blood test result (e.g., from 8 to 7 percent) reduces the risk of eye, kidney and nerve disease by 40 percent.

An average blood glucose of 150 mg/dL (milligrams per deciliter) translates into an A1c of about 7 percent. This is above normal, given that a diagnosis of diabetes is usually given when blood sugar levels reach about 126 mg/dL.

### HOW THE A1C TEST WORKS

Hemoglobin A, a protein found inside red blood cells, carries oxygen throughout the body. When there is glucose in the bloodstream, it can actually stick (glycate) to the hemoglobin A protein. More glucose in the blood means that more glucose sticks to hemoglobin, and a higher percent of hemoglobin proteins become glycated.

Once glucose sticks to a hemoglobin protein, it typically remains as long as 120 days or the lifespan of the hemoglobin A protein. Therefore, at any moment, the glucose attached to the hemoglobin A protein reflects the level of the blood sugar over the last two to three months.

The A1c test measures how much glucose is actually stuck to hemoglobin A, or more specifically, what percent of hemoglobin proteins are glycated. Thus, having a 7 percent A1c means that 7 percent of the hemoglobin proteins are glycated.

A patient's A1c level will not change significantly over the course of a few days, but it will shift in response to a change in overall glucose control. It is estimated that the past month will account for about 50 percent of an A1c value, so that value can change within just a few weeks.

## HOW OFTEN IS AN A1C TEST NECESSARY?

Patients with diabetes should initially have their A1c tested every three months. If blood glucose levels are fairly stable and at near-normal levels, testing twice a year may be sufficient. Providers should tell patients what is right for them and enable them to monitor their diabetes management more easily. More frequent A1c tests may be recommended if a patient has recently changed his/her treatment plan.

## WHAT ARE THE LIMITATIONS OF THE A1C TEST?

While the A1c is a good measure of overall glucose control, it cannot replace self-testing of blood glucose. Like other tests, results may vary from lab to lab. The A1c test is not calibrated the same everywhere, though an international effort is under way to standardize the A1c test to a new International Federation of Clinical Chemistry and Laboratory Medicine standard.

A1c results can be misleading when red blood cell survival is prolonged or reduced. Some health conditions can result in falsely high A1c results, as in cases of anemia, or falsely low, as in cases of hemolysis.

When a patient has his/her A1c checked, he/she does not need to worry about fasting; food eaten on the same day won't affect the score.

### References:

"A1c Test." *Diabetes.org*. American Diabetes Association. 10 Sep 2007. [www.diabetes.org/type-1-diabetes/a1c-test.jsp](http://www.diabetes.org/type-1-diabetes/a1c-test.jsp).

"A1c: The Test." *Lab Tests Online*. 29 Aug. 2005. American Association for Clinical Chemistry. 10 Sep 2007.

[www.labtestsonline.org/understanding/analytes/a1c/test.html](http://www.labtestsonline.org/understanding/analytes/a1c/test.html) "If You Have Diabetes, Know Your Blood Sugar Numbers!" National Diabetes Education Program. July 2005. National Institute of Diabetes and Digestive and Kidney Diseases. 10 Sep 2007.

[www.ndep.nih.gov/diabetes/pubs/KnowNumbers\\_Eng.pdf](http://www.ndep.nih.gov/diabetes/pubs/KnowNumbers_Eng.pdf).

"IFCC Standardization of HbA1c." National Glycohemoglobin Standardization Program. Aug. 2007. National Glycohemoglobin Standardization Program. 10 Sep 2007. [www.ngsp.org/prog/IFCCstd.pdf](http://www.ngsp.org/prog/IFCCstd.pdf) <http://diabetes.about.com/od/symptomsdiagnosis/a/HbA1c.htm>

## FOLLOW THROUGH AND FOLLOW UP!

In the United States, mental health problems are the leading cause of people not being able to work, play or do well in school. Mental health problems also may lead to suicide. In many instances, this can be prevented.

Treatment of mental illness can reduce the length of time patients are ill. It can also lower the chance of reoccurring problems.

If a patient is hospitalized for a mental health issue, it is important that he/she follows up with a qualified mental health specialist. Please urge your patients to do this within seven days of getting out of the hospital. Timely, follow-up care can reduce the chance of re-hospitalization for a mental health problem.

If your patient misses the appointment within the first week, make sure you help him/her re-schedule his/her outpatient follow-up visit. It should be within 30 days of his/her recent hospital discharge.



## FOSTERING THE PHYSICIAN-PATIENT RELATIONSHIP TO IMPROVE QUALITY OF CARE

Establishing good relationships with patients, and especially new patients, can be a key factor to achieving improved quality of care. The following includes tips and considerations to keep in mind when interacting with patients:

- While physicians may tend to focus on the science and process of diagnosing an illness, it is important to remember that patients are concerned with their feelings and disruptions to their lives. Patients want to be known as human beings with psychosocial needs and not just the outer covering of an illness. It is possible for patients to have their feelings hurt if they perceive that their illness is being reduced to a mechanical process.
- Soliciting a patient's concerns through open-ended questions such as, "What's been going on since you were here last?" invites the patient to open up and volunteer information. This subtle encouragement may result in patients who are more forthcoming with information and ultimately facilitate a more accurate diagnosis.
- Working on a good patient-physician relationship builds mutual trust, which can translate to improved patient compliance. The patient-physician relationship is usually the best predictor of whether the patient will follow the physician's recommendations and advice.

- Patients should be respected as experts of their own bodies. A solid patient-physician relationship can foster mutual respect that opens the door to merge the physicians' scientific knowledge with patients' insights of what is going on with their health.
- It is not uncommon for patients to complain that their physicians do not offer explanations, answer questions or even notify them of test results. These complaints may be the result of miscommunication, but they can be reduced or even eliminated through a strong patient-physician relationship where both parties are comfortable in offering additional information and asking questions.
- A physician who is proactive in reaching out to patients who seldom or never come into the office for medical care may foster better patient-physician relationships. Even if these are patients who do not suffer from chronic illness, it is important to communicate the importance of preventive screening. The education provided could help the physician's efforts and the patient's trust that quality care will be provided.

Source:

*Charting the Doctor-Patient Relationship. Seaman, B. Available at: [www.spiralnotebook.org/chartingthedoctorpatientrelationship/index.html](http://www.spiralnotebook.org/chartingthedoctorpatientrelationship/index.html)*

## HIV IS STILL A MAJOR THREAT IN NYC

New York City remains the epicenter of the HIV/AIDS epidemic in the United States. More than 100,000 New Yorkers are living with the infection, and thousands are unaware of their status. From 2001–2007, the number of New Yorkers living with HIV/AIDS has increased by more than 17,000. New HIV infections among young men who have sex with men have been rising over the past decade, compared with men who have sex with men older than 30, where infection rates have been declining. Each year, more than 1,000 people in New York City first find out they are HIV-positive when they are already sick with AIDS.

Approximately 75,000 New Yorkers were diagnosed in 2008 with gonorrhea, syphilis and chlamydia, and many more remain undiagnosed and untreated. These infections can cause infertility, genital tract cancers, miscarriages and infections in newborns. Individuals with these sexually transmitted infections are two to five times more likely to acquire HIV. HIV-infected individuals who also have other sexually

transmitted infections are more likely to transmit HIV to their sex partners. Thus, screening, testing and treatment/management of other sexually transmitted infections are important and effective tools to prevent the spread of HIV.

### FREE AND CONFIDENTIAL CLINICS

Although we understand that most individuals may want to be examined and, if necessary, treated by their primary care provider, the Health Department does provide free and confidential STD clinics to the public. Clinic locations, phone numbers and hours of operation are available at [www.nyc.gov/html/doh/html/std/std2.shtml](http://www.nyc.gov/html/doh/html/std/std2.shtml) or by dialing **311** in New York City.

Minors do NOT need parental consent for examination and treatment. For additional information in New York City, call **311**. These clinics are located in all five boroughs, with some having Saturday hours.

Source: [www.nyc.gov/html/doh/html/tcny/tcny05.shtml](http://www.nyc.gov/html/doh/html/tcny/tcny05.shtml).

# PROVIDER REPORTING OF COMMUNICABLE DISEASES AND OUTBREAKS

## IN NEW YORK CITY

For immediate reporting of any suspected or confirmed illness caused by a potential biological threat agent (e.g., anthrax, smallpox, tularemia or plague) or other disease of urgent public health concern (e.g., avian influenza or SARS), please call the following numbers and ask to speak to the Department of Health and Mental Hygiene (DOHMH).

### Doctor on Call:

On Monday–Friday from 9am–5pm, call the Bureau of Communicable Disease at **1-212-788-9830**. At all other times, call the Poison Control Center at **1-212-764-7667**.

Please note: Section 11.03(b) of the New York City Health Code requires the immediate reporting by telephone of a suspected outbreak among three or more persons of any disease or condition and of any unusual manifestation of disease in an individual.

You may contact DOHMH Monday–Friday from 9am–5pm. To report a communicable disease, call the Bureau of Communicable Disease at **1-212-788-9830**.

At all other times—nights, weekends or holidays—call the Poison Control Center at **1-212-764-7667**.

## IN NEW YORK STATE

Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (*10NYCRR 2.10*). Although physicians have primary responsibility for reporting, school nurses, laboratory directors, infection control practitioners, daycare-center directors, health care facilities, state institutions and any other individuals or locations providing health care services are also required to report communicable diseases.

Reports should be made to the local health department in the county in which the patient resides and need to be submitted within 24 hours of diagnosis. However, some diseases warrant prompt action and should be reported immediately to local health departments by phone. A list of diseases and information on properly reporting them can be found at [www.health.state.ny.us/professionals/diseases/reporting/communicable/physicians\\_and\\_providers/docs/communicable\\_diseases\\_reporting\\_requirements.pdf](http://www.health.state.ny.us/professionals/diseases/reporting/communicable/physicians_and_providers/docs/communicable_diseases_reporting_requirements.pdf).

For more information on communicable disease reporting, call your local health department or the New York State Department of Health's Bureau of Communicable Disease Control at **1-518-473-4439** or after hours at **1-866-881-2809**. To obtain reporting forms (DOH-389), call **1-518-474-0548**. Health care personnel in New York City should use the Universal Reporting Form (PD-16), which is downloadable at [www.nyc.gov/html/doh/downloads/pdf/hcp/urf-0803.pdf](http://www.nyc.gov/html/doh/downloads/pdf/hcp/urf-0803.pdf). Those belonging to NYC MED can complete and submit the form online at [www.nyc.gov/health/nycmed](http://www.nyc.gov/health/nycmed).

Sources: [www.nyc.gov/html/doh/html/hcp/hcp.shtml#report](http://www.nyc.gov/html/doh/html/hcp/hcp.shtml#report);  
[www.health.state.ny.us/professionals/diseases/reporting/communicable/index.htm](http://www.health.state.ny.us/professionals/diseases/reporting/communicable/index.htm)





## TB IS A SERIOUS THREAT

Tuberculosis (TB) remains a public health threat, with cases of TB reported in all regions and all age groups in the state in 2008.

New York State's 1,200 cases of TB in 2008 was the third-highest behind California and Texas, and reflected a 2 percent increase over 2007. Worldwide, TB is among the leading causes of death from infectious disease, with approximately 2 million deaths each year.

Transmission of TB can be prevented by effective treatment and follow up. Early diagnosis is critical so that individuals can be treated and persons with whom the patient has had contact can be evaluated. Individuals with compromised immune systems from conditions such as HIV, cancer, renal insufficiency or diabetes are at higher risk for TB.

### REPORTING REQUIREMENTS FOR TUBERCULOSIS

#### Reporting suspected and confirmed tuberculosis

Reporting of suspected or confirmed TB is mandated under the New York State Sanitary Code (10NYCRR 2.10) and New York City Health Code Article 11, Sections 11.03, 11.05 and 11.47(a).

The NYS DOH Communicable Disease Reporting Requirements mandate tuberculosis should be reported immediately to the local health department by phone followed by submission of a confidential case report form (DOH-389).

In NYC report all patients suspected and confirmed with TB to the New York City Department of Health and Mental Hygiene (DOHMH), Bureau of Tuberculosis Control, within 24 hours of diagnosis or clinical suspicion.

#### Reporting by telephone and on the URF

Suspected and confirmed TB patients may be reported by telephone to the TB Hotline, 1-212-788-4162, but a completed Universal Reporting Form (URF) must follow within 48 hours. The URF should be faxed to the Bureau of Tuberculosis Control at 1-212-788-4179 and the original mailed to the Bureau of Tuberculosis Control, DOHMH at 253 Broadway, Room 602, CN-72, NY, NY 10007. The URF can also be completed online, by first creating an account on NYC-MED at [www.nyc.gov/health/nycmed](http://www.nyc.gov/health/nycmed). Assistance is available by calling 1-888-NYC-MED9 or 1-212-442-3384.

Medical providers must report these patients even though microbiologists and pathologists are also required to report findings consistent with TB.

Report any suspected or confirmed cases of tuberculosis disease, including:

- Positive AFB smears
- Positive nucleic acid amplification tests
- Positive M. TB cultures
- Pathology findings consistent with TB
- Start of TB treatment with 2 or more anti-TB drugs
- Positive test for TB infection (either a Mantoux test or an FDA approved blood test) in children younger than 5 years

## Patient follow-up

The treating physician should also report whether the patient completed treatment and the outcome of the patient (cured, failed, relapsed, lost, moved) or whether treatment was discontinued if the patient was found not to have TB. Physicians must assist the DOHMH in its efforts to evaluate persons suspected of having TB and in patient follow-up.

Case managers will be in contact with the treating physicians to request updates and ensure that appropriate treatment and monitoring is being conducted. A Report of Patient Services Form (TB 65) may need to be completed.

## Reporting TB-related evaluation and treatment of contacts

Medical providers are required, under Section 11.47(b) of the New York City Health Code, to report to the DOHMH, when requested, all information on the evaluation, testing, and treatment of individuals who have been in contact with a person with active TB disease.

## Inquiries and forms

### NYC

To inquire further about reporting procedures, please call the Surveillance Office at the Bureau of Tuberculosis Control at 1-212-788-4162. Obtain the Universal Reporting Form at [home2.nyc.gov/html/doh/html/hcp/hcp-rf.shtml](http://home2.nyc.gov/html/doh/html/hcp/hcp-rf.shtml).

### NYS

For more information on communicable disease reporting, call your local health department or the New York State Department of Health's Bureau of Communicable Disease Control at 1-518-473-4439 or, after hours, at 1-866-881-2809. To obtain reporting forms (DOH-389), call 1-518-474-0548.

#### Sources:

[nyc.gov/html/doh/html/tb/tb.shtml](http://nyc.gov/html/doh/html/tb/tb.shtml)

[www.health.state.ny.us/professionals/diseases/reporting/communicable/](http://www.health.state.ny.us/professionals/diseases/reporting/communicable/)

[nyc.gov/html/doh/html/hcp/hcp-reporting.shtml](http://nyc.gov/html/doh/html/hcp/hcp-reporting.shtml)

[www.health.state.ny.us/press/releases/2009/2009-03-24\\_tuberculosis\\_day\\_release.htm](http://www.health.state.ny.us/press/releases/2009/2009-03-24_tuberculosis_day_release.htm)

### NYC TB Provider Hotline: 1-212-788-4162

- To report cases and obtain forms
- To access patient information from the TB registry
- To obtain expert medical consultation
- To get more information about TB services
- To refer patients for testing or treatment

Source: [nyc.gov/health/tb](http://nyc.gov/health/tb)

## MAMMOGRAMS ARE VITAL FOR BREAST CANCER PREVENTION

### ONE OUT OF FOUR NYC WOMEN 40 AND OLDER DOES NOT GET REGULAR MAMMOGRAMS

Breast cancer kills about 1,260 women in New York City every year, and still 23 percent of women 40 and older have not had a recent mammogram.

The NYC Department of Health and Mental Hygiene recommends that women 40 and older get a mammogram every one to two years. Women with a family history of breast cancer should seek expert medical advice about whether to begin screening before 40 years of age and how often to get screened. Screening mammography is an important way to identify potential cancers at an earlier stage and has been shown to reduce deaths from breast cancer.

Source: [www.nyc.gov/html/doh/html/cancer/cancerbreast.shtml](http://www.nyc.gov/html/doh/html/cancer/cancerbreast.shtml)



# MODEL OF CARE

## COLLABORATIVE PROGRAM IS DEDICATED TO IMPROVING MEMBERS' OVERALL HEALTH

The Model of Care for Medicare beneficiaries in Special Needs Plans (SNP) has evolved since 2003 to include health risk assessments (HRA) and individualized care plans (ICP).

WellCare reaches out to SNP members within 90 days of joining our plan and then annually to conduct an HRA. Then WellCare builds a team for each member that is dedicated to improving his/her health by coordinating care. This team, the interdisciplinary care team (ICT), works with a care manager to create an ICP by analyzing and incorporating the results of the HRA. An ICP will include short- and long-term goals and objectives as well as measurable outcomes.

The care manager may contact you to become part of the ICT.

Some Model of Care outcomes the ICT will strive to achieve are:

- Reduce hospitalizations and skilled nursing facility placements
- Improve self-management and independence

- Improve mobility and functional status
- Improve pain management
- Improve quality of life as self-reported
- Improve satisfaction with health status and health service

A member enrolling in one of WellCare's SNPs under the new Model of Care requirements for 2010 will receive:

- Health assessments to identify risks and concerns
- An individualized care plan
- Coordination of care through a care manager
- Transition of care across health care settings and providers

If you have any questions, please contact your Provider Relations representative or call Medicare Provider Services at 1-800-278-5155.

# CLINICAL COVERAGE GUIDELINES AVAILABLE ON THE WEB

WellCare has made Clinical Coverage Guidelines (CCGs) available on our Web site, [www.wellcare.com](http://www.wellcare.com).

The CCGs are evidence-based documents detailing the medical necessity of given procedures or technologies. The guidelines set consistent criteria for the coverage of a procedure or technology, leading to greater consistency and efficiency in clinical decision making. This consistency and efficiency result in better provider-company interactions and increase the quality of our members' health.

Follow this path to access the guidelines:

[www.wellcare.com](http://www.wellcare.com) > *Provider Resources* > *Clinical Coverage Guidelines*

The guidelines are arranged alphabetically and are formatted as PDF files. If you wish to search by keyword or acronym to find a particular CCG, please type CTRL-F and in the "Find and Replace" dialog box, type the keyword or acronym you wish to search by.



## CHILD ABUSE REPORTING IS MANDATORY

Physicians and other health care providers are required by law to report suspected child abuse or maltreatment to the New York State Central Register (SCR) of Child Abuse and Maltreatment.

Mandated reporters are required to report suspected child abuse or maltreatment when, in their official or professional role, they are presented with a reasonable cause to suspect child abuse or maltreatment. Reasonable cause to suspect child abuse or maltreatment means that, based on your rational observations, professional training and experience, you have a suspicion that the parent or other person legally responsible for a child is responsible for harming that child or placing that child in imminent danger of harm.

### INDICATORS OF PHYSICAL ABUSE MAY INCLUDE:

- Injuries to the eyes or both sides of the head or body (accidental injuries typically only affect one side of the body)
- Frequent injuries of any kind (bruises, cuts and/or burns), especially if the child is unable to provide an adequate explanation of the cause. These may appear in distinctive patterns such as grab marks, human bite marks, cigarette burns or impressions of other instruments.
- Destructive, aggressive or disruptive behavior
- Passive, withdrawn or emotionless behavior
- Fear of going home or fear of parent(s)

### INDICATORS OF SEXUAL ABUSE MAY INCLUDE:

- Symptoms of sexually transmitted diseases
- Injury to genital area
- Difficulty and/or pain when sitting or walking
- Sexually suggestive, inappropriate or promiscuous behavior or verbalization
- Expressing age-inappropriate knowledge of sexual relations
- Sexual victimization of other children

### INDICATORS OF MALTREATMENT CAN INCLUDE:

- Obvious malnourishment, listlessness or fatigue
- Stealing or begging for food
- Lack of personal care—poor personal hygiene, torn and/or dirty clothes
- Untreated need for glasses, dental care or other medical attention



- Frequent absence from or tardiness to school
- Child inappropriately left unattended or without supervision

### HOW DO I REPORT?

As soon as you suspect abuse or maltreatment, you must report your concerns by telephone to the SCR. The SCR is open 24 hours a day, seven days a week. You are not required to notify the parents or other persons legally responsible either before or after your call to the SCR.

The telephone numbers are: Mandated Reporter—**1-800-635-1522**, Public Hotline—**1-800-342-3720**.

Two counties run hotlines that may be used instead of the SCR: Onondaga—**1-315-422-9701**, Monroe—**1-585-461-5690**.

Verbal reports to any of the hotlines must be followed within 48 hours by a written report on Form LDSS-2221A to the local Child Protective Services. A copy of this mandated reporter form can be obtained by contacting your local CPS office, or by accessing the New York State Office of Children and Family Services (OCFS) Web site at [www.ocfs.state.ny.us](http://www.ocfs.state.ny.us) (click on the “Forms” and “LDSS-2221A” links).

For further information about child abuse and maltreatment, visit [www.ocfs.state.ny.us](http://www.ocfs.state.ny.us).

# PROVIDER FORMULARY UPDATE

## GENERIC NEWS:

The generic drugs listed below are now available:

BRAND NAME	GENERIC NAME	THERAPEUTIC CLASS
Augmentin® 250mg-62.5mg/5mL Suspension	Amoxicillin Trihydrate/Potassium Clavulanate 250mg-62.5mg/5mL Suspension	Anti-infective Agent
Casodex® 50mg Tablets	Bicalutamide 50mg Tablets	Antiandrogen Agent
Colazal 750mg Capsules	Balsalazide Disodium 750mg Capsules	Gastrointestinal Agent
Plan B® 0.75mg Tablets	Next Choice 0.75mg Tablets (Quantity Limit: 4 Tablets = 2 boxes/31 days) (Medicare Only)	Emergency Oral Contraceptive
Prograf® 0.5mg, 1mg, 5mg Capsules	Tacrolimus Anhydrous 0.5mg, 1mg, 5mg Capsules (Prior Authorization) (Medicare Only)	Immunosuppressive Agent

The following additions have been made to the WellCare Medicare Formulary:

ADDITIONS	
• Colcrys™ 0.6mg Tablets	• Ketorolac 300mcg/10mL Vial (QL: 20mL/31 days)
• Cytra-2 Oral Solution (QL: 3600mL/31 days)	• Nitro-Bid® 2% Ointment
• Cytra-3 Solution (QL: 3600mL/31 days)	• Norpace® CR 100mg Capsules SA
• GaviLyte-G Solution	• Ofloxacin 0.3% Otic Drops
• Hectorol® 1mcg Capsules	• Prezista® 150mg Tablets
• Invega® Sustenna™ 39mg, 78mg, 117mg, 156mg, 234mg Prefilled Syringes (PA)	• Pristiq® 50mg, 100mg Tablets (PA: new starts only)
• Ixiaro® 6mcg/0.5mL Syringe	

PA = Prior Authorization    QL = Quantity Limit

## 2010 PLAN YEAR UPDATES

Listed below are some important changes that are going to be made to the WellCare Medicare Formulary for the 2010 plan year, effective **January 1, 2010**:

REMOVALS	
• Actonel® 5mg, 30mg, 35mg, 75mg, 150mg Tablets	• Benicar® 5mg, 20mg, 40mg Tablets
• Actonel® with Calcium 35mg/125mg Tablets	• Benicar HCT® 20/12.5mg, 40/12.5mg, 40/25mg Tablets
• Alendronate Sodium 5mg, 10mg Tablets	• Betimol® 0.25%, 0.5% Ophthalmic Solution
• Alphagan® P 0.1%, 0.15% Ophthalmic Solution	• Caduet® 2.5/10mg, 2.5/20mg, 2.5/40mg, 5/10mg, 5/20mg, 5/40mg, 5/80mg, 10/10mg, 10/20mg, 10/40mg, 10/80mg Tablets
• Androgel® 25mg/2.5gm, 50mg/5gm	• Celebrex® 50mg, 100mg, 200mg, 400mg Capsules
• Androgel® Pump 1%	• Clarinex® 5mg Tablets, 0.5mg/mL Syrup
• Android® 10mg Capsules	• Clarinex® Reditabs® 2.5mg, 5mg
• Avelox® 400mg Tablets	• Clarinex-D® 24 Hour 5/240mg Tablets

*chart continued on next page*

## REMOVALS—continued

• Enbrel® 25mg Powder for Injection, 25mg/0.5mL & 50mg/mL Solution for Injection, SureClick™ 50mg/mL Autoinjector	
• Humalog® Insulin	• Nexium® I.V. 20mg, 40mg
• Humalog® Mix 50/50 Insulin	• Nizatidine 150mg, 300mg Capsules
• Humalog® Mix 75/25 Insulin	• Prevacid® 15mg, 30mg Capsules
• Humulin® 70/30 Insulin	• Prevacid Solutab™ 15mg, 30mg
• Humulin® N Insulin	• Proair® HFA Metered Dose Inhaler
• Humulin® R Insulin	• Rozerem® 8mg Tablets
• Humulin® R U-500 (Concentrated) Insulin	• Solaraze® 3% Gel
• Lipitor® 10mg, 20mg, 40mg, 80mg Tablets	• Stalevo® 50mg, 75mg, 100mg, 125mg, 150mg, 200mg Tablets
• Lofibra® 54mg Tablets, 67mg Capsules, 134mg Capsules, 160mg Tablets, 200mg Capsules	• Travatan® 0.004% Ophthalmic Solution
• Loratadine 10mg Tablets	• Travatan Z® 0.004% Ophthalmic Solution
• Nexium 20mg, 40mg Capsules; 20mg, 40mg Packets	• Vesicare® 5mg, 10mg Tablets

## ADDITIONS PA = Prior Authorization QL = Quantity Limit

• Cimzia® Kit (PA)	• Novolog® Insulin (QL: 60mL/31 days)
• Demeclocycline HCL 150mg, 300mg Tablets	• Novolog® Mix 70/30 Insulin (QL: 60mL/31 days)
• Enjuvia™ 0.3mg, 0.45mg, 0.625mg, 0.9mg, 1.25mg Tablets	• Promacta® 25mg, 50mg Tablets (PA: new starts only)
• Granisetron HCL 1mg Tablets (QL: 31/31 days)	• Tazorac® 0.05%, 0.1% Topical Cream and Gel
• Granisetron HCL 0.1mg/mL, 1mg/mL Solution for Injection (QL: 10mL/31 days)	• Testim® 1% Topical Gel (PA)
• Mesalamine 4g/60mL Rectal Enema Suspension	• Vfend® 50mg, 200mg Tablets; 200mg Powder for Injection; 400mg/mL Powder for Suspension (PA)
• Lansoprazole 15mg, 30mg Delayed-Release Capsules	• Xalatan® 0.005% Ophthalmic Solution (QL: 2.5mL/31 days)
• Novolin® 70/30 Insulin (QL: 60mL/31 days)	• Xenazine® 12.5mg, 25mg Tablets (PA)
• Novolin® N Insulin (QL: 60mL/31 days)	• Xolair® 150mg Powder for Injection (PA)
• Novolin® R Insulin (QL: 60mL/31 days)	

## PLANNED MARKET DRUG WITHDRAWALS

COMPANY NAME	DRUG NAME	DATE OF REMOVAL	COMMENTS
King Pharmaceuticals	Intal® Inhaler	July 31, 2009	Intal® Inhaler will be available until current inventories are exhausted.
Targacept, Inc.	Inversine® 2.5mg Tablets	September 30, 2009	Inversine® 2.5mg Tablets will be available until current supplies are exhausted.
Novo Nordisk	<ul style="list-style-type: none"> <li>• Novolin® R InnoLet®</li> <li>• Novolin® N InnoLet®</li> <li>• Novolin® 70/30 InnoLet®</li> <li>• Novolin® R PenFill®</li> <li>• Novolin® N PenFill®</li> <li>• Novolin® 70/30 PenFill®</li> </ul>	December 31, 2009	Effective January 1, 2010, the listed insulin delivery devices will no longer be available. Claims will adjudicate until supplies are exhausted.

## EXPANDED SYRINGE ACCESS DEMONSTRATION PROGRAM (ESAP)

Pharmacies registered in New York State's Expanded Syringe Access Demonstration Program (ESAP) may sell or furnish up to 10 syringes at a time to adults 18 or older without a prescription. Under this program, health care facilities and health care providers (doctors and others who can prescribe syringes) may also furnish syringes.

Under New York State Public Health Law (Section: 3381, Chapter 56, Laws of 2000), persons 18 and older can legally possess hypodermic needles and syringes obtained through ESAP. These syringes and needles may be purchased or obtained without prescription from participating licensed pharmacies, hospitals, nursing homes, community health centers, doctors, nurse practitioners and physician assistants. Syringes and needles may also be purchased with a prescription at a licensed pharmacy or obtained from an authorized syringe-exchange program.

**Possession of syringes in accordance with the Public Health Law is legal.** Persons legally possessing syringes are not subject to arrest or prosecution under the Penal Law. Lawful sale or furnishing of syringes by participating providers/facilities is also legal. This applies to both registered ESAP providers and authorized syringe-exchange programs.

The actual sale or possession of illegal drugs is a crime and puts you at risk of arrest and criminal prosecution.

To find a nearby pharmacy that participates in this program (ESAP) call:

NYS Department of Health

1-800-541-AIDS (English)

1-800-369-SIDA (Spanish)

Sources: [www.health.state.ny.us/publications/9359.pdf](http://www.health.state.ny.us/publications/9359.pdf)  
[www.nyc.gov/html/doh/html/cd/cdhepc-needleex.shtml](http://www.nyc.gov/html/doh/html/cd/cdhepc-needleex.shtml)



## E-PRESCRIBING ENABLES BETTER CLINICAL OUTCOMES

Are you familiar with e-Prescribing? E-Prescribing, or electronic prescribing, is an electronic way of communicating among prescribers, pharmacies, pharmacy benefit providers and health plans regarding prescription and prescription-related information. Various IT vendors provide this service.

E-Prescribing is a valuable resource that contributes to improved clinical outcomes and safety for patients. WellCare strongly encourages physicians to take advantage of this resource.

E-Prescribing gives you the ability to:

- Enhance the clarity of prescription information by eliminating the need for hand-written prescriptions;
- Obtain formulary and benefit information directly from WellCare, providing you with information such as formulary alternatives, prior authorization contact information and co-payment information instantly;
- Obtain a patient's medication-fill history with WellCare, including the prescriptions written by specialists or

other prescribers, decreasing the likelihood of drug-to-drug interactions;

- Obtain fill-status notifications alerting you when a medication has been picked up by your patient, partially filled, or returned to stock by the pharmacy because of failure of the patient to pick up the prescription;
- Communicate with retail pharmacies electronically, reducing the number of phone calls and increasing the efficiency of office personnel; and
- Improve the overall quality of care that you provide to your patients.

It is important to note that e-Prescribing **does not apply to controlled substances**. All providers must have National Provider Identifier (NPI) numbers in order to participate in e-Prescribing. To obtain an NPI, or to get more information on NPI, please visit the National Plan and Provider Enumeration System at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.

## TAKE STEPS TO FIGHT VIRAL HEPATITIS

WellCare of New York encourages providers to be on the lookout for all forms of hepatitis when treating members and to take preventive steps against the disease.

### HEPATITIS A

Hepatitis A is an acute liver disease caused by the hepatitis A virus (HAV), lasting from a few weeks to several months. It does not lead to chronic infection.

Transmission can result from ingestion of fecal matter, even in microscopic amounts, from close person-to-person contact or ingestion of contaminated food or drinks.

Hepatitis A vaccination is recommended for all children starting at age 1. Travelers to certain countries and others are also at risk.

### HEPATITIS B

Hepatitis B is a liver disease caused by the hepatitis B virus (HBV). It ranges in severity from a mild illness, lasting a few weeks (acute), to a serious long-term (chronic) illness that can lead to liver disease or liver cancer.

Transmission can result from contact with infectious blood, semen, and other body fluids from having sex with an infected person, sharing contaminated needles to inject drugs, or from an infected mother to her newborn.

Hepatitis B vaccination is recommended for all infants, older children and adolescents who were not vaccinated previously, and adults at risk for HBV infection.

### HEPATITIS C

Hepatitis C is a liver disease caused by the hepatitis C virus (HCV). HCV infection sometimes results in an acute illness, but most often becomes a chronic condition that can lead to cirrhosis of the liver and liver cancer.

Transmission can result from contact with the blood of an infected person, primarily through sharing contaminated needles to inject drugs.

There is currently no FDA-approved vaccine for hepatitis C.



### HEPATITIS D

Hepatitis D is a serious liver disease caused by the hepatitis D virus (HDV) and relies on HBV to replicate. It is uncommon in the United States.

Transmission can result from contact with infectious blood, similar to how HBV is spread.

There is currently no FDA-approved vaccine for hepatitis D.

### HEPATITIS E

Hepatitis E is a serious liver disease caused by the hepatitis E virus (HEV) that usually results in an acute infection. It does not lead to a chronic infection. While rare in the United States, hepatitis E is common in many parts of the world.

Transmission can result from ingestion of fecal matter, even in microscopic amounts. Outbreaks are usually associated with contaminated water supply in countries with poor sanitation.

There is currently no FDA-approved vaccine for hepatitis E.

Source: [www.cdc.gov/hepatitis/index.htm](http://www.cdc.gov/hepatitis/index.htm)

# IMPROVING THE HEALTH OF PATIENTS WHO USE DRUGS

Please take the following steps when dealing with patients who use drugs:

- Ask all patients about substance use, including drugs, alcohol and tobacco.
- Discuss health problems and risky behaviors that may be associated with drug use.
- Screen, vaccinate and treat patients who use drugs for infectious diseases, physical health problems and mental-health issues commonly linked to drug use.
- Offer brief interventions for risky or harmful drug use and provide buprenorphine for treatment of opioid dependence.
- Refer patients to drug treatment and harm reduction programs when necessary.

## IDENTIFYING SUBSTANCE USE

Some patients who inject drugs may have evidence of skin puncture (including track marks) or soft tissue infections (cellulitis, abscesses); intranasal users can have damage to the nasal mucosa or septum. **However, most people who use drugs do not have physical signs of drug use.**

### Asking About Substance Use

Asking about substance use, including drugs, tobacco and alcohol, is an important component of eliciting a patient's medical history. Patients may be more comfortable answering questions about drug use when these questions are linked to the reason for their visit or to routine preventive health issues. Ask about drugs at the same time you ask about tobacco or alcohol use and in the same nonjudgmental tone.

Ask:

- What drugs or prescription medications have you ever used not as prescribed?
- In the past 3 months, have you used drugs or prescription medications not as prescribed?

Many patients will not be willing to discuss their drug use during the first visit, and patterns of use may change; ask again at follow-up visits. Urine drug screening is not a substitute for asking patients about drug use. With the exception of marijuana, which may be detected in the urine for a month or more following use, a positive drug screen usually reflects only recent use (past few days or week). Be aware that commonly used assays do not test for all drugs and do not distinguish between prescription and illicit opioid use.

## ASSESSING SUBSTANCE USE

Substance use can range from low- to high-risk. If patients answer “yes” to any recent drug use, screen them with the National Institute on Drug Abuse's Modified ASSIST (NIDA-Modified ASSIST), available at [www.drugabuse.gov/nidamed/screening](http://www.drugabuse.gov/nidamed/screening), to characterize the risk level of an individual's pattern of substance use (drugs, tobacco and alcohol). Classifying a patient's drug use as low-, moderate- or high-risk will help guide your subsequent intervention.

A full drug-use and treatment history will inform your discussion about risks of use and options for treatment.

Ask all patients who report drug use in the past 3 months about:

1. Drug use history: *Which drugs? Amount, frequency, route of administration and duration?* Use of more than one drug is the norm rather than the exception. Using substances like opioids (heroin or prescription opioids) or cocaine on a daily or almost-daily basis almost always meets criteria for dependence.
2. Behavioral risk assessment: *Have you ever injected any drug, overdosed or had a near overdose?*  
  
*How do drugs affect choices you make about sex (partners, condom use)?* Prior overdose is the strongest predictor of subsequent overdose. Using such drugs as alcohol, cocaine and methamphetamine has been linked to high-risk sexual activity among HIV-infected patients in primary care.
3. Treatment history: *Have you ever been in drug treatment? If yes, what type of treatment? Was it helpful, and did you achieve a period of abstinence or reduced use?*

Additional information and resources are available at [www.nyc.gov/html/doh/downloads/pdf/chi/chi28-3.pdf](http://www.nyc.gov/html/doh/downloads/pdf/chi/chi28-3.pdf)

# PROMOTE COLORECTAL CANCER SCREENINGS

## RESEARCH FROM AMERICAN CANCER SOCIETY

WellCare encourages providers to screen members for colorectal cancer.

Health plans like WellCare, the Centers for Medicare & Medicaid Services (CMS) and other third-party payers are using physician's colorectal cancer screening rates as a quality measure.

## HOW PHYSICIANS CAN IMPROVE SCREENING RATES

### • Your Recommendation

Regular recommendations by patients' physicians are the single most important factor in patient decisions whether to be screened for colorectal cancer.

### • An Office Policy

Research shows that creating an office policy that encourages all associates to promote screening is the foundation of a systematic approach to colorectal cancer screening. Ensure clinical practices are built on clear policies, well-designed systems, effective communication and quality reviews.

### • An Office Reminder System

Creating and implementing an office reminder system for physicians, your patients or both can help people with busy schedules and competing priorities to remember their screening appointments.

### • Effective Communication

Effective communication is a cornerstone of an excellent practice. A physician's communication skills are related to patient satisfaction, which could influence willingness to be screened.

## RESOURCES FOR CLINICIANS

The "Primary Care Clinician's Evidence-Based Toolbox and Guide," which provides suggestions for more efficient screening practices more efficient, was created by clinicians for clinicians and may help improve colorectal cancer screening rates in actual practice.

This guide includes:

- A checklist for increased screenings, office policies, reminder systems and communication aids
- Sample office screening policies
- Template telephone scripts for patient follow-up
- Sample reminder letters to patients at average and increased risk
- A sample tracking sheet for preventive care examinations
- Descriptions of electronic reminder systems for patients and physicians

The guide is available online at the Web sites of the National Colorectal Cancer Roundtable ([www.nc crt.org](http://www.nc crt.org)) and the American Cancer Society ([www.cancer.org/colonmd](http://www.cancer.org/colonmd)).

If implemented, the best practices contained in this guide may help improve colorectal cancer screenings rates among your patients.

Sources:

American Cancer Society, Inc. No. 080152, 2009. Available at [www.cancer.org](http://www.cancer.org).

National Colorectal Cancer Roundtable. Web site: [www.nc crt.org](http://www.nc crt.org).  
Jefferson. Web site: [www.jefferson.edu](http://www.jefferson.edu).

# REFERRING MEDICARE MEMBERS FOR SUPPLEMENTARY BENEFITS

The chart on the right outlines WellCare's service vendors for routine dental, hearing and vision benefits in 2010. When you refer Medicare members for any of these services, please remind them that using in-network providers helps lower health care and member out-of-pocket costs.

Please note that availability of benefits and level of coverage varies by plan and county. For more information, please call WellCare Medicare Provider Services at 1-800-278-5155.

BENEFIT	VENDOR NAME
Routine Dental Services, such as preventive care	Healthplex Dental
Routine Hearing Exam & Hearing Aid	HearUSA Inc.
Routine Vision Exam & Eye Wear	Block Vision



WellCare of New York, Inc.  
110 5th Ave., 3rd Floor  
New York, NY 10011

PRSR STD  
U.S. POSTAGE  
**PAID**  
WELLCARE

NY011526\_WCG\_NEW\_ENG  
©WellCare 2010 NY\_10\_09

30470

## S\*T\*A\*R\*T THE NEW YEAR

### ENCOURAGE PATIENTS TO QUIT SMOKING

Quitting smoking works best when the person is prepared. Help your patients start by communicating a new acronym: **START** and five important steps:

- S = Set** a quit date.
- T = Tell** family, friends and coworkers that you plan to quit.
- A = Anticipate** and plan for the challenges you'll face while quitting.
- R = Remove** cigarettes and other tobacco products from your home, car and work.
- T = Talk** to your doctor about getting help to quit.

For more information visit, [www.smokefree.gov](http://www.smokefree.gov).

New York City has made tremendous progress in reducing the number of smokers: Between 2002 and 2007, there were 300,000 fewer adult smokers, and youth smoking also declined significantly. Despite these successes, smoking remains the leading cause of preventable death, killing more than 7,400 New Yorkers every year. Individuals who die of smoking-related illnesses lose an average of 14 years of life.

Smoking greatly increases the risk of heart disease, stroke, cancer and many other illnesses. Second-hand smoke is also dangerous, and can lead to many of these same health problems. Infants whose parents smoke are more likely to die of sudden infant death syndrome, and children who live with a smoker are more likely to have asthma, bronchitis, ear infections and pneumonia, and are twice as likely to become smokers themselves.

For additional resources to quit smoking in NYC:

Call **311** or

**New York State Smokers' Quitline**

Call for **FREE** coaching and support

**1-866-NY-QUITS (1-866-697-8487)**

*Source. [www.smokefree.gov/qg-preparing-steps.aspx](http://www.smokefree.gov/qg-preparing-steps.aspx), October 19, 2009.*

## WEB SITES PROVIDE EMERGENCY INFORMATION

NYC Healthcare PREPARES is a Department of Health and Mental Hygiene Web site dedicated to health care emergency preparedness.

Health care facilities and emergency planners from New York City and across the country are welcome to use this Web site to access protocols, guidance, templates and other tools that are useful for preparedness. Updates to new protocols, guidance documents and a calendar of upcoming events will occur frequently as new materials become available. Access the Web site at: [www.nyc.gov/html/doh/html/bhpp/bhpp.shtml](http://www.nyc.gov/html/doh/html/bhpp/bhpp.shtml).

The following information for health care providers is available at the New York State Department of Health (NYS DOH) Web site:

- Bioterrorism readiness
- Chemical terrorism
- Radiological terrorism

The Web site can be found at:

[www.health.state.ny.us/environmental/emergency/providers.htm](http://www.health.state.ny.us/environmental/emergency/providers.htm)

## 2010 MEDICARE BENEFIT YEAR

### CO-PAYMENT CHANGES

The 2010 benefit year is fast approaching. Many of WellCare's Medicare Advantage plans' co-payment amounts have increased for the 2010 year. This increase is the direct result of reductions in reimbursement from the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage plans in 2010.

Along with higher co-payment amounts in 2010, WellCare members may be responsible for more than one co-payment at a single provider on a single date of service. Multiple co-payments may be charged when certain diagnostic services are performed in a professional or outpatient hospital setting. There are five possible categories of services for which a co-payment may be charged in addition to the office or facility visit co-payment:

Members are only responsible for one co-payment per category of services per provider and per date of service. Therefore, a patient who has multiple basic diagnostic tests during your office visit should be responsible for the appropriate office visit co-payment plus one \$20 co-payment for all basic tests.

Remember, an office or facility visit co-payment only applies when a consultation or procedure is performed.

Renewing Medicare Advantage members were advised of co-payment changes via their Annual Notification of Changes (ANOC) for the 2010 benefit year, which was mailed to members in October 2009.

For any questions about co-payment changes, please call Provider Services at 1-800-278-5155 or contact your Provider Relations representative.

CATEGORY OF SERVICES	2010 AMOUNT
Lab services (i.e., urinalysis)	\$0 co-payment
Basic diagnostic radiological services (flat film X-ray only)	\$0 co-payment
Basic diagnostic tests (i.e., allergy test, EKG)	\$20 co-payment
Advanced diagnostic tests (cardiac stress test only)	\$50 co-payment
Advanced diagnostic radiological services (i.e., MRI, ultrasound)	\$50 co-payment



# DIABETES AND EYE DISEASE—8 FACTS YOU SHOULD KNOW

Eye disease associated with diabetes can cause blindness. Educating your diabetic patients on the following facts about diabetic eye disease can help lower their risk of vision loss.

## 1. DIABETES MAY LEAD TO EYE DISEASE

Several factors influence whether patients develop diabetic eye disease (diabetic retinopathy) including blood glucose control, blood pressure levels and genetics. Keeping blood glucose and HbA1c levels close to normal can reduce their chance of developing diabetic eye disease.

## 2. THERE MAY BE NO WARNING

While some patients receive no warning signs of diabetic eye disease, others sometimes experience the following symptoms:

- Blurry vision
- Double vision
- Rings, flashing lights or blank spots
- Dark spots or floaters
- Pain or pressure in the eyes
- Trouble seeing out of the corners of your eyes

## 3. DIABETIC PATIENTS NEED ANNUAL DILATED EYE EXAMS

Regular eye exams are important for early detection of eye disease. If identified at an early stage, diabetic eye disease can be successfully treated before severe vision loss occurs.

## 4. CONTROLLING DIABETES WON'T PREVENT DIABETIC EYE DISEASE

Even if your patient's blood glucose levels are steady, diabetic eye disease can still develop. However, carefully managing blood glucose levels may slow the onset and progression of diabetic retinopathy.

## 5. PATIENTS WITH DIABETES MAY DEVELOP GLAUCOMA

Patients with diabetes are 40 percent more likely to suffer from glaucoma than people without diabetes. The longer a patient has had diabetes, the more common it is for glaucoma to develop. Advancing age is also a risk for the development of glaucoma.

## 6. PATIENTS WITH DIABETES MAY DEVELOP CATARACTS

If your patient has diabetes, his/her chances of developing cataracts are increased. Patients with diabetes tend to get cataracts at a younger age and have them progress faster.

## 7. DIABETIC RETINOPATHY DAMAGES THE RETINA

When blood glucose levels become too high, blood vessels in the retina weaken. The blood and fluid inside the blood vessels begins to leak. New blood vessels grow (neovascularization), but they are fragile and may leak fluid. This causes the retina to swell and become deprived of nutrients and oxygen, causing vision loss and possibly blindness.

## 8. LASER SURGERY SLOWS THE PROGRESSION OF DIABETIC EYE DISEASE

Laser surgery can be used to shrink the abnormal blood vessels or seal leaking blood vessels in the retina. The risk of vision loss from diabetic retinopathy is greatly reduced in some patients after having laser surgery.

Sources:

*Understanding Diabetes Related Eye Conditions Royal National Institute of Blind People (RNIB), 10 June 2006.*

*Troy Bedinghaus, O.D., About.com; Updated April 1, 2009. About.com Health's Disease and Condition content is reviewed by the Medical Review Board*

