BLUE REVIEW℠

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November 2018

Education & Reference

Importance of Adult Body Mass Index Measurement and Management

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Blue Cross Community Centennial℠ (Medicaid)

2019 Blue Cross Community Centennial Prior Authorization Updates

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Medicare

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Providers who treat dually eligible Medicare and Medicaid members are required by the Centers for Medicare and Medicaid Services (CMS) to complete an annual Dual-Special Needs Plan (DSNP) training on DSNP plan benefits and requirements, including coordination of care and Model of Care elements. Blue Cross Medicare Advantage will inform providers of their specific DSNP Model of Care (MOC) training requirements and expectations.

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Federal Employee Program® (FEP)

FEP Benefits Changes for Infliximab Effective Jan. 1, 2019

The autoimmune drug infliximab will be covered as a medical benefit for Blue Cross and Blue Shield Federal Employee Program (FEP) members who receive their first infusion on or after Jan. 1, 2019. Now, members may receive infliximab under either pharmacy or medical benefits. Members currently receiving infliximab under pharmacy benefits, will continue to receive it under pharmacy benefits after Jan. 1, 2019. FEP will notify these members.

If a member receiving infliximab prior to Jan. 1, 2019, changes FEP benefit plans or health insurers, they will receive the drug under medical benefits regardless of how they previously received it.

Infliximab brand names are Remicade®, Inflectra® and Renflexis®. It is an intravenous antibody that is used to treat many life-long inflammatory health problems.

Documentation During Pregnancy

Communication between health care professionals during the course of a patient's pre-pregnancy, pregnancy, and postpartum medical journey is important. It is recommended that when furnishing obstetrical care to your patient, certain information be documented in the patient's chart to facilitate more effective coordination and continuity of care via records shared with other providers.

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It is important for a hospital patient's regular providers and practitioners to know details about the care a patient receives during an inpatient hospital stay. The hospital discharge summary is the key source for this information.

Studies have shown that providing timely, structured discharge summaries to Primary Care Providers (PCP) and other practitioners involved in the patient's care favorably impacts readmission rates, patient satisfaction and continuity of care.

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gets and to receive communication from you concerning that care. It is important to follow the American Diabetes Association (ADA) position statement on diabetic retinopathy and screening recommendations, which was updated in 2017.

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Not Yet Contracted?

Providers who are participating in commercial BCBSNM products are not automatically participating providers in Blue Cross Community Centennial. If you are interested in becoming a Blue Cross Community Centennial provider, please call 505-837-8800 or 1-800-567-8540.

Reminder: Update your Enrollment Information

Due to Centennial Care requirements, all enrollment information (changes to demographics, licensure or certification, provider status, etc.) must be updated on the NM Medicaid Provider Web Portal.

Such services are funded in part with the State of New Mexico.

BCBSNM Website

It's important for you to stay informed about news that could affect your practice. BCBSNM offers many ways to stay informed via our website, bcbsnm.com/provider, and our provider newsletter, *Blue Review*. Signing up is easy.

Medical Policy Updates

Approved new or revised medical policies and their effective dates are usually posted on our website the 1st and 15th of each month. These policies may impact your reimbursement and your patients' benefits. These policies are located under the Standards & Requirements tab at bcbsnm.com/provider.

Claims Inquiries

Our Provider Service Unit (PSU) handles all provider inquiries about claims status, eligibility, benefits and claims processing for BCBSNM members. For the BCBSNM BlueCard® PSU, call 800-222-7992. For out-of-area claims inquiries, call 888-349-3706.

• Network Services Contacts and Related Service Areas

• Network Services Regional Map

Do We Have Your Correct Information?

Maintaining up-to-date contact and practice information helps to ensure that you are receiving critical communications and efficient reimbursement processes. Please complete our quick and easy online form for any changes to your contact or practice information.

Member Rights and Responsibilities

BCBSNM policies help address the issues of members participating in decision making regarding their treatment; confidentiality of information; treatment of members with dignity, courtesy and a respect for privacy; and members' responsibilities in the practitioner-patient relationship and the health care delivery process.

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bcbsnm.com/provider

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Importance of Adult Body Mass Index Measurement and Management

For many people, balancing life challenges is difficult when it comes to maintaining a healthy weight. Discussing a healthy weight with patients and identifying causes of weight gain or loss are critical conversations that may help prevent disease.

According to the Center for Disease Control and Prevention (CDC), people who have obesity, compared to those with a normal or healthy weight, are at increased risk for many serious diseases and health conditions including the following:
- All-causes of death (mortality)
- High blood pressure (Hypertension)
- High LDL cholesterol, low HDL cholesterol, or high levels of triglycerides (Dyslipidemia)
- Type 2 diabetes
- Coronary heart disease
- Stroke
- Gallbladder disease
- Osteoarthritis (a breakdown of cartilage and bone within a joint)
- Sleep apnea and breathing problems
- Some cancers (endometrial, breast, colon, kidney, gallbladder, and liver)
- Low quality of life
- Mental illness such as clinical depression, anxiety, and other mental disorders
- Body pain and difficulty with physical functioning[1]

Body Mass Index (BMI) and waist circumference are two measures that you can use as screening tools to estimate weight status in relation to potential disease risk. BMI can be used as a screening tool but is not diagnostic of the body fatness or health of an individual. To calculate BMI divide the patient's weight in kilograms by the square of their height in meters, or use a BMI Calculator or determine BMI by finding height and weight in this BMI Index Chart[2]

BMI ranges correspond to classifications such as "overweight" or "morbidly obese," and can be a window into obesity-related conditions. Keep in mind that a health assessment is needed to evaluate an individual's health status and risk.

Getting in the habit of measuring height, weight and BMI with **every visit** may allow patients to better understand how their life style choices are impacting their health. Healthcare Effectiveness Data and Information Set (HEDIS) measures provider performance by requiring a biennial BMI measurement for patients 20 years of age or older. For patients 18 to 20 years old, a BMI percentile is also required at least every two years.

Providers should work together with patients to promote healthy choices regarding weight management and improving BMI. Printed materials or online links regarding weight and associated risks may be beneficial for your patients. Identify achievable goals with individuals and celebrate efforts and achievements!

[1]https://www.cdc.gov/healthyweight/effects/

[2]https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html

BCBSNM Preauthorization Changes Beginning Jan. 1, 2019

Effective Jan. 1, 2019, Blue Cross and Blue Shield of New Mexico (BCBSNM) will be updating preauthorization requirements for fully insured members with PPO, Blue Advantage℠ HMO, Blue Community℠ HMO, Blue Preferred Plus℠, and HMO network plans. Additionally, these preauthorizations will also apply to fully insured membership with Blue Choice℠ PPO and Administrative Services Only (ASO) membership with Blue Choice PPO with the Health Advocacy Solutions and Wellbeing Management option. These updated requirements are expected to include the application of preauthorization to more services. This may reduce post-service denials for lack of medical necessity.

Patient eligibility and benefits should be verified prior to every scheduled appointment. Eligibility and benefit information includes membership verification, coverage status and, preauthorization requirements. To obtain fast, efficient, detailed information for BCBSNM members, please access the Availity® Eligibility and Benefits tool located at https://www.availity.com/resources/support/provider-portal-registration. Please note that you must be registered with Availity to gain access to this free online tool. Additional tip sheets are available on the BCBSNM Provider website under Claims and Eligibility. Watch for future updates to the preauthorization requirements list reflecting the 2019 changes on the preauthorizations page at bcbsnm.com/provider.

For additional information, please contact your Provider Network Representative.

Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSNM. Availity is solely responsible for the products or services they offer. If you have any questions regarding any of the products or services they offer, you should contact the vendor(s) directly.

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been prior authorized for benefits is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have questions, contact the number on the member's ID card.

Specialty Pharmacy Infusion Site of Care: Preauthorization Requirements

Effective Jan. 1, 2019, preauthorization will be required for select infusion drugs for the Blue Cross and Blue Shield of New Mexico (BCBSNM) members in the networks listed below. These are drugs that are administered by health care professionals and typically covered under the member's medical benefit.

- Blue Community HMO℠
- Blue Advantage HMO℠
- Blue Preferred℠
- Blue HMO℠
- Blue PPO℠
- Blue EPO℠

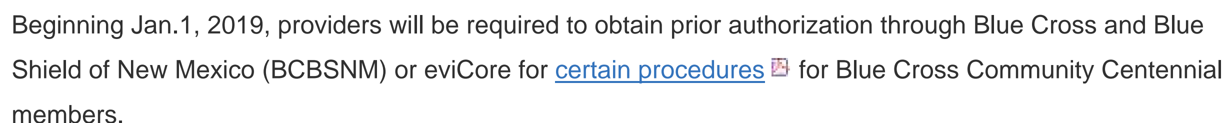
Starting on Jan. 1, 2019, if you are prescribing these select infusion drugs, you will need to submit a preauthorization request to BCBSNM prior to administration of the drug. To request preauthorization, use our online tool, iExchange®. You may also call the number on the member's BCBSNM ID card for assistance.

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been prior authorized or predetermined for benefits is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have questions, contact the number on the member's ID card.

iExchange is a trademark of Medecision, Inc., a separate company that provides collaborative health care management solutions for payers and providers. BCBSNM makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Medecision. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

2019 Blue Cross Community Centennial℠ Prior Authorization Updates

November 21, 2018



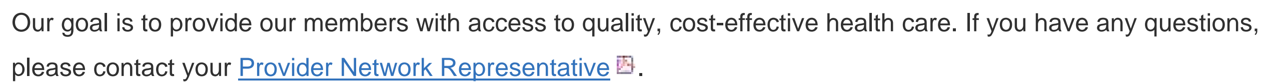
Beginning Jan.1, 2019, providers will be required to obtain prior authorization through Blue Cross and Blue Shield of New Mexico (BCBSNM) or eviCore for certain procedures for Blue Cross Community Centennial members.

Services performed without benefit prior authorization may be denied for payment in whole or in part, and you may not seek reimbursement from members.

Member eligibility and benefits should be checked prior to every scheduled appointment. Eligibility and benefit quotes include membership status, coverage status and other important information, such as applicable copayment, coinsurance and deductible amounts. It is strongly recommended that providers **ask to see the member's ID card for current information** and a photo ID to guard against medical identity theft.

To obtain benefit prior authorization through BCBSNM for the care categories noted below, you may continue to use iExchange®. This online tool is accessible to physicians, professional providers and facilities contracted

with BCBSNM. For more information or to set up a new account, refer to the iExchange page in the Provider Tools section of our Provider website.



Our goal is to provide our members with access to quality, cost-effective health care. If you have any questions, please contact your Provider Network Representative.

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been prior authorized or predetermined for benefits is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have questions, contact the number on the member's ID card.

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eviCore is a trademark of eviCore healthcare, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of BCBSNM.

Such services are funded in part with the State of New Mexico.

Required Cultural Competency Training Available Online

The Centers for Medicare and Medicaid Services (CMS) considers cultural competency a national health concern that plays a role in improving patient care and satisfaction. CMS defines cultural competency as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients.

The New Mexico Human Services Department (HSD) requires all providers contracted within a New Mexico Medicaid Network, like Blue Cross Community Centennial℠, to take annual cultural competency training. This training is intended to include all cultures and not be limited to any particular group and is designed to address the needs of racial, ethnic, and linguistic populations that may experience unequal access to health services.

Providers may take cultural competency training through Blue Cross and Blue Shield of New Mexico (BCBSNM) by utilizing our easy-to-use online platform. If you have already taken a cultural competency program with another MCO, you must complete a digital attestation for BCBSNM confirming the completion of your training for the year.
Effective Jan. 1, 2019, BCBSNM will begin displaying a designation in the online provider directory for providers who complete the annual training or attestation. Providers who do not

complete this annual requirement, either by completing the training or the attestation, will be removed from the BCBSNM online directory and may be terminated from the Blue Cross Community Centennial network.

If you have any questions regarding the cultural competency training or attestation form, please contact your Provider Network Representative.

Proper Claim Filing Procedures for Blue Cross Community Centennial℠ Behavioral Health Providers

Blue Cross and Blue Shield of New Mexico (BCBSNM) is actively involved in programs to detect and address potential fraud and/or other issues related to inappropriate reimbursements of claims for health care services billed to BCBSNM.

In the course of reviewing claims and records submitted by multiple behavioral health (BH) providers, BCBSNM determined that many providers are submitting Medicaid claims for services rendered by non-independently licensed BH providers.

Guidance issued to BH providers by the State of New Mexico Medical Assistance Division on January 23, 2015, addressed billing for non-independently licensed clinicians. This guidance identifies the following agencies as eligible to bill for the services of non-independently licensed providers when supervised according to clinical supervision requirements:

- A Community Mental Health Center (CMHC);
- A Federally Qualified Health Center (FQHC);
- An Indian Health Services (IHS) hospital and clinic;
- A PL 93-638 tribally operated hospital and clinic;
- The Children, Youth and Families Department (CYFD);
- A hospital and its outpatient facility; or
- A Core Service Agency (CSA)

Additionally, effective October 1, 2015, Behavioral Health Agencies (BHA) (provider type 432) can apply for certification to provide supervision and bill for services provided by a non-independently licensed BH clinician, as identified in the accompanying attachment. Each BHA is responsible for contacting the New Mexico Behavioral Health Services Division (NMBHSD) to determine if it qualifies for the program as a Supervising entity. For more information about obtaining this certification, please contact the NMBHSD via email at: HSD.CSMbhsd@state.nm.us.

Once certified by NMBHSD, BHAs should provide their Provider Network Representative with a copy of the Supervisory Certification Letter, so that it may be included in the BHA file.

If you don’t know your designated Provider Network Representative, reference the following link: https://www.bcbsnm.com/pdf/network_contacts.pdf.
Providers that participate with BCBSNM for Blue Cross Community Centennial are reminded that their contracts with BCBSNM require timely, complete and accurate claims filing, as well as their timely identification, reporting, and refunding of overpayments.

BCBSNM will continue to review claims for BH services and reserves all rights and remedies available to BCBSNM for providers' noncompliance with direction issued by NMBHSD or failures to adhere to other regulatory or contractual requirements, including, but not limited to recoupment and contract termination.

If you have questions, please contact your Provider Network Representative.

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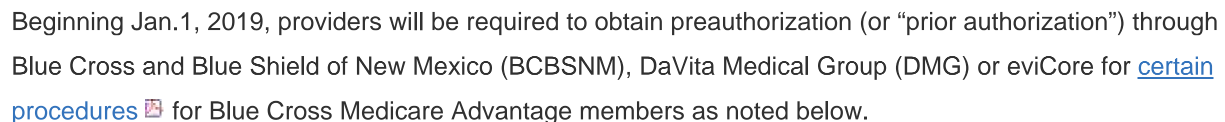

Claims for services for which preauthorization is required by BCBSNM and not obtained by Network Providers may be denied for payment and Network Providers may not seek reimbursement from members.

Member eligibility and benefits should be checked prior to every scheduled appointment. Eligibility and benefit quotes include membership status, coverage status and other important information, such as applicable copayment, coinsurance and deductible amounts. It is strongly recommended that providers **ask to see the member's ID card for current information** and a photo ID to guard against medical identity theft. When services may not be covered, members should be notified that they may be billed directly.

A referral to an out-of-network provider which is necessary due to possible network inadequacy or for continuity of care must be reviewed by the BCBSNM Utilization Management department or DMG (if the member is attributed to DMG this information will be reflected on the ID card) prior to a BCBSNM member receiving care from the out-of-network provider.

To obtain preauthorization through BCBSNM for the care categories noted below, you may continue to use iExchange®. This online tool is accessible to physicians, professional providers and facilities contracted with BCBSNM. For more information or to set up a new account, refer to the iExchange page in the Provider Tools section of our Provider website.

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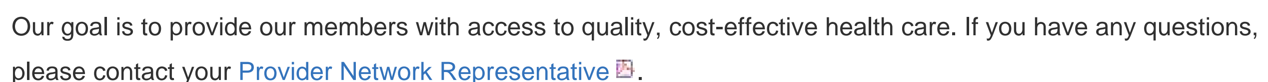

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Reversals and corrections may occur when claim adjudication results have been modified from a previous claim report. The method for revision is to reverse the entire claim and resend with modified data. Provider level adjustments are reported in the PLB segment within the 835 ERA from Blue Cross and Blue Shield of New Mexico (BCBSNM).

We've prepared a helpful resource to assist you with interpreting the PLB segment on 835 ERAs related to claims submitted for the following government programs members:

- Blue Cross Medicare Advantage (HMO)SM
- Blue Cross Medicare Advantage (PPO)SM

We encourage you to refer to the Interpreting the 'PLB' Segment on the 835 ERA - Government Programs Only document, located in the Claims & Eligibility section of our Provider website. This document provides additional details regarding adjustment codes that may appear in the PLB segment, in accordance with the requirements as specified within the Health Insurance Portability and Accountability Act of 1996 (HIPAA)-mandated Technical Report Type 3 (TR3).* The document also includes information on PLB segment definitions and examples, as well as how to locate overpaid claims on the ERA and paper Provider Claim Summary (PCS).
Please share this document with your practice management/hospital information system software vendor, and/or your billing service or clearinghouse, if applicable.

*The HIPAA mandated ASC X12 Health Care Claim / Payment Advice (835) TR3 is available for purchase on the Washington Publishing Company (WPC) website at wpc-edi.com. WPC is an independent third-party vendor that is solely responsible for its products and services.

CMS-Required Training for Dual-Special Needs Plans

Providers who treat dually-eligible Medicare and Medicaid members are required by the Centers for Medicare and Medicaid Services (CMS) to complete an annual Dual-Special Needs Plan (DSNP) training on DSNP plan benefits and requirements, including coordination of care and Model of Care elements.

You may also recognize this program as Blue Cross Medicare Advantage Dual Care (HMO-SNP)℠.

Because it is important for providers to complete the required training, Blue Cross Medicare Advantage will inform providers of their specific DSNP Model of Care (MOC) training requirements and expectations. Providers can submit proof of completion by:

1. Completing a computer-based training module issued to them and/or their provider group or,
2. Submitting an attestation after a live training provided by a Network Representative

Blue Cross Medicare Advantage will retain these attestations in each provider's file. The adherence of the required DSNP training is critical to our member's health and care.

If you have any questions about the training or would like a one-on-one training session, please reach out to your assigned Provider Network Representative at 1-800-567-8540.

Documentation During Pregnancy

Communication between health care professionals during the course of a patient's pre-pregnancy, pregnancy, and postpartum medical journey is important. It is recommended that when furnishing obstetrical care to your patient, at least the following be documented in the patient's chart to facilitate more effective coordination and continuity of care via records shared with other providers:

- **Prenatal Visit in First Trimester**
    - Prenatal risk assessment with counseling to include education, complete medical and obstetrical history, physical exam (e.g. ACOG Form)
    - Prenatal lab reports (OB panel/TORCH antibody panel/Rubella antibody test/ABO/ Rh)
    - Ultrasound, EDD

- **Duration of Prenatal Visits**
    - Prenatal flow sheet (ACOG, EMR, or other)
    - All progress/visit notes for duration of pregnancy
    - Ultrasound reports and all consult reports
- **Delivery**
    - Documents, such as hospital delivery records, verifying member had a live birth
    - If the patient had a non-live birth, records that document the non-live birth
- **Postpartum**
    - Documentation of a postpartum visit on or between 21-56 days after delivery
    - Postpartum office visit progress notation that documents an evaluation of weight, blood pressure, breast exam, abdominal exam, and pelvic exam

Thank you for caring for our Blue Cross and Blue Shield Service Benefit Plan members.

This letter is informational. It is not medical advice. Providers must use their own medical judgment in determining the appropriate course of treatment for each patient.

Importance of Hospital Discharge Summaries

It is important for a hospital patient's regular providers and practitioners to know details about the care a patient receives during an inpatient hospital stay. The hospital discharge summary is the key source for this information.

Studies have shown that providing timely, structured discharge summaries to Primary Care Providers (PCP) and other practitioners involved in the patient's care favorably impacts readmission rates, patient satisfaction and continuity of care. One study found that at discharge, approximately 40 percent of patients have test results pending and that 10 percent of those require action. PCPs and patients may be unaware of these results. [1,3]

A prospective cohort study found that one in five patients discharged from the hospital to their homes experienced an adverse event, defined as an injury resulting from issues with medical management rather than from the underlying disease, within three weeks of discharge. This study found 66 percent of these were drug-related adverse events. [2,3]
Key information that should be included in every discharge summary include:

- course of treatment
- diagnostic test results
- follow-up plans
- diagnostic test results pending at discharge
- discharge medications with reasons for changes/ medication reconciliation
- Communication between the in-patient medical team and the PCP is critical to ensure a smooth and durable transition of the patient to the next level of care.

Blue Cross and Blue Shield of New Mexico applauds practitioners who have adopted a structured approach to receiving discharge summaries as this demonstrates best practice.

This letter is informational. It is not medical advice. Providers must use their own medical judgment in determining the appropriate course of treatment for each patient.

Sources

[1] Roy CL, Poon EG, Karson AS, et al. Patient safety concerns arising from test results that return after hospital discharge. Ann Intern Med. 2005;143(2):121–8.

[2] Forster AJ, Murff HJ, Peterson JF, et al. The incidence and severity of adverse events affecting patients after discharge from the hospital. Ann Intern Med. 2003;138(3):161–7.

[3] Snow, V., MD. (2009). Transitions of Care Consensus Policy Statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine. Journal of Hospital Medicine, 4(6), 364-370. doi:10.1002

Referring Diabetic Patients for Annual Eye Exam – Federal Employee Program

Many practitioners refer their diabetic patients to eye care specialists for an annual eye examination. It is important for the referring providers to know details about the care a patient gets and to receive communication from you concerning that care. It is important to follow the American Diabetes Association (ADA) position statement on diabetic retinopathy and screening recommendations, which was updated in 2017:

- **Initial Exams:**
  - Within five years of diagnosis for adults who have Type 1 diabetes
  - At the time of diagnosis for adults with Type 2 diabetes
- **Exam Frequency:**
  - Every two years in the absence of retinopathy
  - Annually in the presence of retinopathy
  - At more frequent intervals in the presence of progressive retinopathy and/or deterioration of vision due to disease progression
- **Pregnancy:**
  - Educate women who are planning to be or are pregnant and who also have diabetes about the risk of diabetic retinopathy developing or progressing
  - Perform an eye exam prior to or at the time of diagnosis of pregnancy, during every trimester, and one year after delivery in the presence of pre-existing Type 1 or Type 2 diabetes
- **Exams:**
  - Should not be substituted by retinal photography
  - Should be conducted as mentioned above[1]

To help improve outcomes, consider the following:

- **Incorporate** ADA recommendations into practice. Following the above recommendations will ensure best practice for patients.
- **Gather** patient information. Ask the patient about their diabetes history, medications they are taking, symptoms they are experiencing and if they have any questions.
- **Educate** your patients. Help them understand why a retinal exam for patients with diabetes is different than an eye exam for glasses and why it is essential to help prevent future problems.
- **Reassure** your patients with diabetes that a yearly retinal exam might be covered by medical insurance.
- **Submit** claims accurately. When submitting a claim for a diabetic patient eye exam, be sure to include "diabetes" as a diagnosis to ensure proper payment. A list of diabetes codes for diabetic eye exams and procedures is included in this communication for your reference.
- **Communicate** eye care exam results with the patient's Primary Care Physician.

We thank you for furnishing covered services to our Blue Cross and Blue Shield Service Benefit Plan members. Please remember to share eye care exam results with the patient's PCP. We have included a template for this purpose. Working together, we can improve the care of people with diabetes. Please contact NMFEPQIPrograms@BCBSNM.com if you would like further information. You can also learn more about diabetic retinopathy at http://care.diabetesjournals.org/content/40/3/412.

Codes to Identify Eye Exams and procedures for Diabetic Retinal Disease**

67028	67030	67031	67036	67039 - 67043	67101	67105	67107	67108
67110	67112	67113	67121	67141	67145	67208	67210	67218
67220	67221	67227	67228	92002, 92004	92012	92014	92018	92019
92134	92225 - 92228	92230	92235	92240	92250	92260	99203 - 99205	99213 - 99215
99242 - 99245	3072F	2022F	2024F	2026F				

HCPCS

S0620	**S0621**		**S3000**

****Based on NCQA 2019 HEDIS® specifications.**

<EXAMPLE OF A NOTE TO SEND TO REFERRING PROVIDER>

(Insert Practice Logo in this Space)

Diabetic Eye Examination Report **(Insert Practice Name)**

____

TO: ___________________________ **RE:** _______________________________

________________________________ _____________________________________

________________________________ _____________________________________

________________________________ _____________________________________

FAX: _________________________ **Current Eye Medications:**

____

____

Date of Examination: _______________

Dilated fundus examination: ☐**Y** ☐**N**

Result of Examination:

☐No diabetic retinopathy at this time

☐Proliferative diabetic retinopathy

☐Non-proliferative diabetic retinopathy

Glaucoma examination: ☐**Y** ☐**N**

Result of examination: ☐**Present** ☐**Suspected** ☐**Absent**

Other ocular conditions:

Recommendations:

☐ No treatment is necessary at this time, just yearly monitoring for any changes

☐ Close monitoring of ocular health status with a review in 3 months

☐ Close monitoring of ocular health status with a review in 6 months

☐ Referral to___________________________

☐ An appointment has been made with___________________________

I have discussed these findings with the above patient and stressed the importance of regular monitoring of eye health. Please let me know if I can provide you with more information. It's a pleasure to participate in the continued care of our mutual patient.

This letter is informational. It is not medical advice. Providers must use their own medical judgment in determining the appropriate course of treatment for each patient.

[1]Diabetic Retinopathy: A Position Statement by the American Diabetes Association, Sharon D. Solomon, Emily Chew, Elia J. Duh, Lucia Sobrin, Jennifer K. Sun, Brian L.VanderBeek, Charles C. Wykoff, Thomas W. Gardner, Diabetes Care, Mar 2017, 40 (3) 412-418; **DOI:** 10.2337/dc16-2641