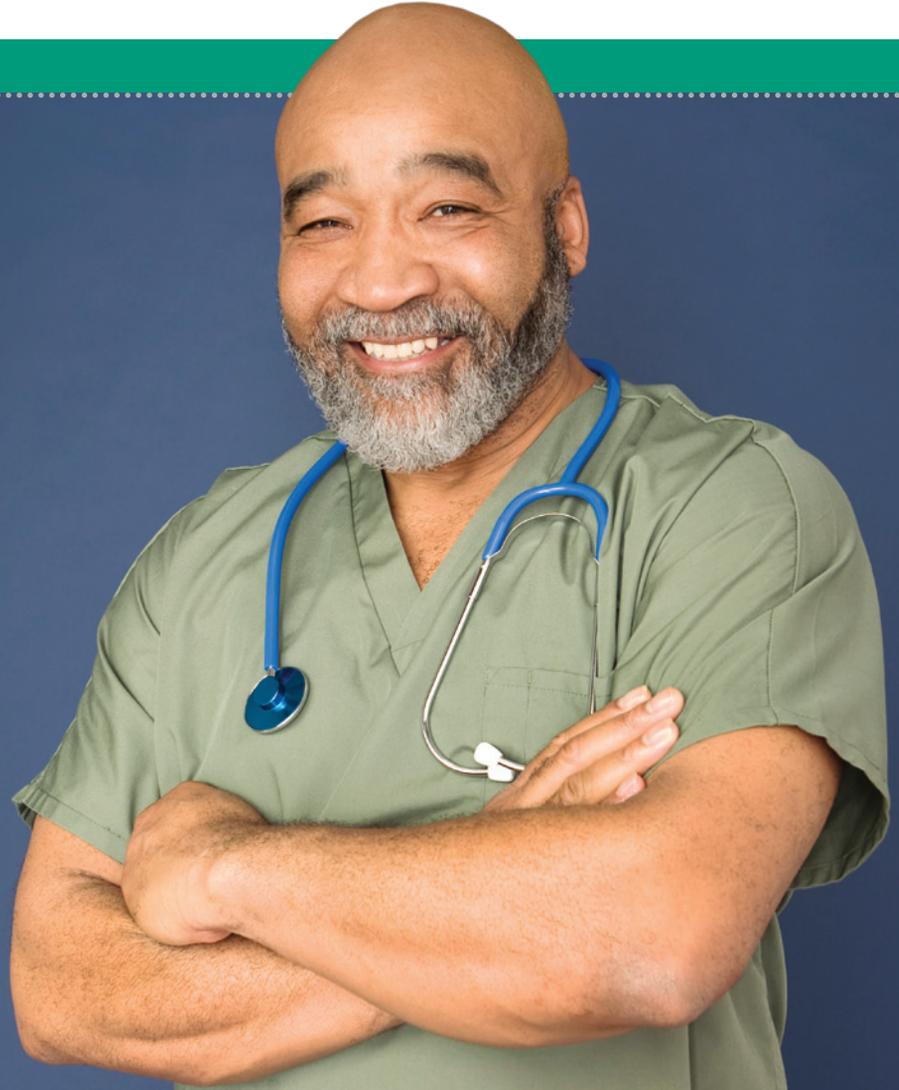


# provider report



WINTER 2014



## Peer-to-Peer Review

Home State Health Plan will send you and your patient written notification any time we make a decision to deny, reduce, suspend or stop coverage of certain services. The denial notice includes information on the availability of a medical director to discuss the denial decision.

In the event that a request for medical services is denied due to lack of medical necessity, a provider can request a peer-to-peer review with our medical director on the member's behalf. The medical director may be contacted by calling Home State Health Plan at **1-855-694-HOME (4663)**.

A case manager may also coordinate communication between the medical director and the requesting practitioner as needed.

The denial notice will also inform you and the member about how to file an appeal. In urgent cases, an expedited appeal is available and can be submitted verbally or in writing.

Please remember to always include sufficient clinical information when submitting prior authorization requests to allow for Home State Health Plan to make timely medical necessity decisions based on complete information.

## Your Credentialing Rights

**During the credentialing** and recredentialing process, Home State Health Plan obtains information from various outside sources, such as state licensing agencies and the National Practitioner Data Bank. Practitioners have the right to review primary source materials collected during this process. The information may be released to practitioners only after a written and signed request has been submitted to the Credentialing Department. If any information gathered as part of the primary source verification process differs from data submitted by the practitioner on the

credentialing application, Home State Health Plan will notify the practitioner and request clarification. A written explanation detailing the error or the difference in information must be submitted to Home State Health Plan within 30 days of notification of the discrepancy in order to be included as part of the credentialing and recredentialing process.

Providers also have the right to request the status of their credentialing or recredentialing application any time by contacting the Credentialing Department at **1-855-694-HOME (4663)**.

## New Technology: What's Covered?

Home State Health Plan evaluates the inclusion of new technology and new application of existing technology for coverage determination on an ongoing basis. We may provide coverage for new services or procedures that are deemed medically necessary. This may include medical procedures, behavioral health procedures or devices.

Requests for coverage will be reviewed and a determination made regarding any benefit changes that are indicated. When a request is made for new technology coverage on an individual case and a plan-wide coverage decision has not been made, Home State Health Plan will review all information and make a determination on whether the request can be covered under the member's current benefits, based on the most recent scientific information available.

For more information, please call **1-855-694-HOME (4663)**.

## » PLANNING ADVANCE DIRECTIVES WITH YOUR PATIENTS

Advance directives can be a sensitive topic to bring up with your patients, but it's important that they understand their right to execute these important documents. Home State Health Plan wants to make sure our members are getting the guidance and information they need, regardless of their current health status.

We encourage you to explain this process to your patients and show them how to file the right forms. Patients should give one copy of the executed advance directive to the person(s) designated to be involved in their care decisions and send one copy to your office so that it can be filed with their medical records. Providers are required to document provision of information and note whether or not patients have an advance directive in their permanent medical records.

During our medical record compliance audits, Home State Health Plan will randomly monitor compliance with this provision. Please contact us at **1-855-694-HOME (4663)** if you would like general information about advance directives or in regards to a specific member.

# The Results Are In: Member Satisfaction Survey

**Home State Health Plan** recently asked members what they thought of our care and services. How patients rate their healthcare is an important measure of quality. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys ask consumers and patients to report on and evaluate their experiences with healthcare. Survey results are submitted to the National Committee for Quality Assurance (NCQA) to meet accreditation requirements. These surveys are completed annually and reflect how our members feel about the care they receive from our providers as well as the service they receive from the health plan. Home State Health Plan will be using the results to help plan on how to improve.

We also want to share the results with you, since you and your staff are a key component of our members' satisfaction.

Here are some key findings from the survey:

Areas where we scored well include:

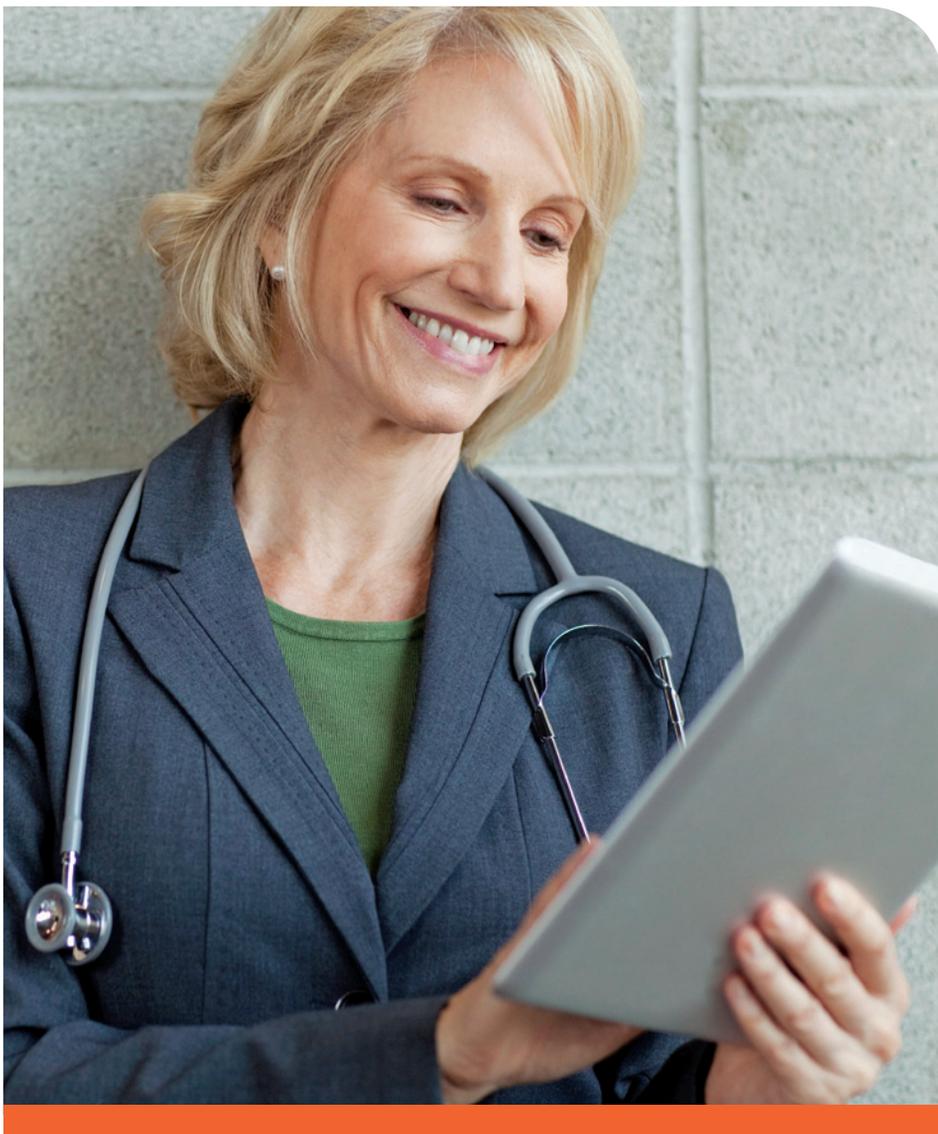
- ▶ Members stated that they like their providers.
- ▶ Members felt that their providers listened to them.

Based on the feedback we received, some of the areas we have been working to improve include:

- ▶ Members have a lack of awareness regarding the identity of their assigned PCP.
- ▶ Members do not recognize the name Home State Health Plan.

Home State Health Plan takes our members' concerns seriously and will work with you to improve their satisfaction in the future.





## ICD-10 Resources and Updates:

### HEALTH PLAN RESOURCES

Please visit the Home State Health Plan's provider resources website with ICD-10 Overview landing pages complete with FAQs, testing instructions and additional resources. You may also contact your local health plan Provider Relations representatives should you have any additional ICD-10 related questions including readiness surveys that require responses.

### INDUSTRY AND HEALTH PLAN UPDATES

#### CMS-1500 Paper Claims Form Change:

In accordance with CMS, the health plan requires ICD-10 codes on paper claims for dates of service (for professional claims) and discharge dates (for institutional claims) as of October 1, 2014. The CMS-1500 Claim

Form has been recently revised with changes including those to more adequately support the use of the ICD-10 diagnosis code set.

The revised form will give providers the ability to indicate whether they are using ICD-9 or ICD-10 diagnosis codes. In accordance with CMS, Home State Health Plan will begin accepting the revised form on January 6, 2014. In accordance with CMS, starting April 1, 2014, the health plan will accept only the revised version of the form. Changes that have been made to the CMS-1500 and UB-04 claim forms are communicated through the National Uniform Claim Committee (<http://nucc.org/>) for the CMS-1500 claim form or the National Uniform Billing Committee (<http://nubc.org/>) for the UB-04, as these groups are responsible for updating paper claim forms on behalf of CMS.

## » Q & A

We recently have received the following questions related to testing and want to share Centene's current stance on testing:

**Q Have you developed your internal/external testing strategy and time-frames? How do we get involved in testing with you?**

**A** The health plans have been ready to conduct RAMP testing for HIPAA file format compliance since July, 2013.

Providers that submit claims via EDI or are interested in submitting claims via EDI can test with the health plan. Direct submitters can test by visiting <https://sites.edifecs.com/index.jsp?centene>. Providers that submit claims through a clearinghouse can communicate this request to the EDI service desk at **1-800-225-2573, ext. 25525** or **EDIBA@centene.com**. Contact the EDI service desk for any questions or requests.

Our end-to-end test strategy is being finalized and we will be ready to test with select providers through 2014. For additional information on testing, please visit the health plan ICD-10 Overview page.

### REIMBURSEMENT/CONTRACTING:

**Q How will the ICD-10 transition impact provider reimbursement? Will you renegotiate the contract to replace ICD-9 codes with ICD-10 codes?**

**A** The ICD-10 conversion was not intended to transform payment or reimbursement; however, it may result in reimbursement methodologies that more accurately reflect patient status and care across the industry. The health plan is evaluating risk mitigation from impact to reimbursement through changes to contracting and clinical operations. Contract remediation will occur on an as-needed basis and is currently being reviewed on a contract-by-contract basis. Any changes will be communicated via existing channels.

## Our HEDIS Performance

HEDIS, the Healthcare Effectiveness Data and Information Set, is a set of standardized performance measures updated and published annually by the National Committee for Quality Assurance (NCQA). HEDIS is a tool used by most of America's health plans to measure performance on important aspects of care and service. HEDIS is designed to provide purchasers and consumers with the information they need to reliably compare the performance of healthcare plans. Final HEDIS rates are typically reported to NCQA and state agencies once a year. Through HEDIS, NCQA holds Home State Health Plan accountable for the timeliness and quality of healthcare services (acute, preventive, mental health, etc.) delivered to its diverse membership. Home State Health Plan also reviews HEDIS rates on an ongoing basis and continually looks for ways to improve our rates. It's an important part of our commitment to providing access to high quality and appropriate care to our members.

# HEDIS for Heart Care

### Cholesterol screening and management

is a HEDIS measure that applies to any patient who has been discharged with acute myocardial infarction (AMI), coronary artery bypass graft or percutaneous coronary interventions, or has a diagnosis of ischemic vascular disease. The HEDIS rate measures the percentage of these patients who had an LDL-C screening performed during the calendar year, and the percentage of those patients with an LDL level less than 100 mg/dL.

The high blood pressure control HEDIS measure applies to patients who have been diagnosed with hypertension (excluding individuals with end-stage renal disease and pregnant women). HEDIS measures the percentage of hypertensive patients with adequate control (defined as a systolic reading of less than 140 mm Hg and a diastolic reading of less than 90 mm Hg).

The HEDIS measure for persistence of a beta-blocker treatment regimen after heart attack applies to patients who were hospitalized and discharged after an AMI. This measure calls for treatment with beta-blockers for six months after discharge. Patients with a known contraindication or a history of adverse reactions to beta-blocker therapy are excluded from the measure. Despite strong evidence of

the effectiveness of drugs for cardiac problems, patient compliance remains a challenge—particularly among Medicaid patients.

**STEPS YOU CAN TAKE:** Continue to suggest lifestyle changes and support such as quitting smoking, losing excess weight, beginning an exercise program and improving nutrition. Stress the value of prescribed medications for managing heart disease. Home State Health Plan can provide educational materials and other resources addressing the above topics. Please encourage your Home State Health Plan members to contact Home State for assistance in managing their medical condition. Home State Health Plan case management staff members are available to assist with patients who have challenges adhering to prescribed medications or have difficulty filling their prescriptions. If you have a member you feel could benefit from our case management program please contact Home State Health Plan's member services at **1-855-694-HOME (4663)** and ask for medical case management.



## HEDIS for Diabetes

The HEDIS measure for comprehensive diabetes care includes adult patients with Type I and Type II diabetes. There are multiple sub-measures included:

- ▶ **HbA1c testing**—completed at least annually. Both CPT codes 83036 and 83037 can be submitted when this test is completed.
- ▶ **HbA1c level**—
  - HbA1c result > 9.0 = poor control (CPT II code 3046F)
  - HbA1c result < 8.0 = good control (CPT II code 3044F)
  - HbA1c result < 7.0 for selected population (CPT code 3044F)

- ▶ **LDL-C testing**—completed at least annually.
  - LDL-C result < 100 (CPT code 3048F)
- ▶ **Dilated retinal eye exam**—annually, unless prior negative exam then every 2 years.
- ▶ **Nephropathy screening test**—at least annually (unless documented evidence of nephropathy).

To improve compliance, we offer specific suggestions for three tests:

- 1 **LDL-C testing:** Remind patients to fast when they come in for an HbA1c test so that you may also complete the LDL testing.

- 2 **Dilated retinal eye exam:** Home State Health Plan can assist your office with finding a vision provider. Our vision vendors support our efforts by contacting members in need of retinal eye exams to assist them in scheduling an appointment.
- 3 **Nephropathy screening test:** Did you know a spot urine dipstick for microalbumin or a random urine test for protein/creatinine ratio are two methods that meet the requirement for nephropathy screening? Submit code 3060F for a positive microalbuminuria test result documented and reviewed. Submit code 3061F for a negative microalbuminuria test result documented and reviewed.

