the Communicator

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Ensuring HEDIS-Compliant Preventive Health Services - Best Practice Strategies

Heart City Health Center in Elkhart, Indiana, scored 100% on their MHS EPSDT on-site reviews and is a previous Summit Award winner, an honor which recognizes quality care and clinical excellence.

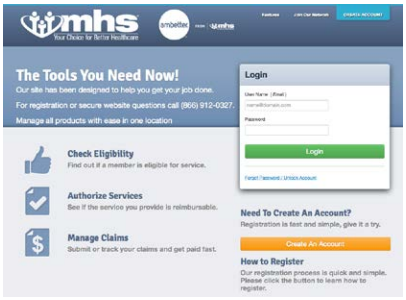
How did they do it?

Following are a few key strategies shared by the health center:

- **Member Identification:** Heart City Health Center uses population health management software to identify patients in need of preventive health services.
- **Targeted Outreach:** Heart City Health Center staff members provide reminder calls to patients needing services identified in monthly reports.
- **Flexible Scheduling:** Practitioners revised their schedules to accommodate more patients (walk-ins, late arrivals, siblings of scheduled patients, etc.).
- **Well-Child Templates:** Heart City Health Center practitioners collaborated with their EHR vendor to develop well-child visit templates modeled after Bright Futures. Free well-child visit templates can also be downloaded from the MHS Provider Forms page.
- **MedTox Lead Screening:** Practitioners utilize this easy method to collect filter paper lead screenings in the office and receive faxed results at no charge.
- **The Opportunistic Visit:** Heart City Health Center practitioners utilize all opportunities, including "sick" visits, to provide preventive health services.

For more details and comprehensive preventive health strategies, please see the full article.

Benefits with the Provider Portal in HIP 2.0



Have you logged in to the MHS Secure Provider Portal lately? Remember, as a security precaution, accounts are disabled after 90 days of inactivity.

You can use the MHS Provider Portal to:

- Manage multiple practices under one account
- Check member eligibility
- View medical history and gaps in care
- Submit and manage claims
- Submit prior authorizations
- Securely contact a plan representative

And more!

Forgot your password? Use the Forgot Password/Unlock Account feature to log in.

JUST A THOUGHT

BY DR. YANCY

Order urine microalbumin along with the HgbA1c. And, recommend a retinal eye exam appointment for all diabetics.

Dr. Eric A. Yancy
MHS Chief Medical Officer and practicing pediatrician

Clinical Practice Guidelines

MHS preventive and clinical practice guidelines are evidence-based and based on the health needs of our members and opportunities for improvement identified as part of the QI program. MHS adopts preventive and clinical practice guidelines that are published by nationally recognized organizations or government institutions. These guidelines have been reviewed by our QI committee, which includes representation from MHS network physicians.

We encourage practitioners to use these guidelines as a basis for developing personalized treatment plans for our members and to aid members in making decisions about their healthcare. MHS measures compliance with these guidelines through monitoring of related HEDIS measures and through random ambulatory medical record audits. MHS utilization management, member education, coverage of services and other areas to which the guidelines apply are consistent with these guidelines. These guidelines are used for both preventive services as well as for the management of chronic diseases. Preventive and chronic disease guidelines available through MHS include:

- ADHD
- Adult and Child Immunizations
- Adult/Pediatric Preventive Care
- Anxiety Disorder
- Asthma and COPD
- Back Pain
- Bipolar Disorder
- Breast Cancer
- Chlamydia Screening
- Coronary Artery Disease
- Diabetes
- Heart Failure and Hypertension
- Hyperlipidemia
- Lead Screening
- Major Depressive Disorder
- Oppositional Defiant Disorder
- Panic Disorder
- Pediatric Medical and Psychiatric Management
- Perinatal Care
- Respiratory Illness
- Schizophrenia
- Sickle Cell
- Stress Disorder
- Substance Use Disorders
- Tobacco Cessation
- Use of Psychotropic Medication
- Weight Management

As with any clinical guidelines, the adopted guidelines are intended to augment, not replace, sound clinical judgment. Guidelines are reviewed and updated at least every two years or upon significant change.

Current preventive and clinical practice guidelines are available online at mhsindiana.com, and may be mailed to practitioners as part of disease management or other quality program initiatives. The guidelines are also available upon request to members.

Peer-to-Peer Review

MHS 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 letter includes information on the availability of an MHS 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 physician can request a peer-to-peer review with the MHS Medical Director on the member's behalf. Requests for peer-to-peer reviews should be made within 10 calendar days of denial notification. To set up a call, please contact Medical Affairs at 1-855-696-2613.

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

Advance Directives

MHS is committed to ensuring that its members know of, and are able to, avail themselves of their rights to execute advance directives. MHS is equally committed to ensuring that its providers and staff are aware of, and comply with, their responsibilities under federal and state law regarding advance directives.

Any provider delivering care to MHS members must ensure that members receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the member's medical record.

MHS will monitor compliance with this provision. Providers may be audited annually. If you have any questions regarding advance directives, please contact MHS Medical Management at 1-877-647-4848.

Unlimited Transportation Benefits for HIP Plus Members

MHS is excited to announce that all HIP Plus members now receive unlimited transportation benefits. HIP Plus members have the same benefits as Hoosier Healthwise, HIP State Plan, HIP Maternity and pregnant HIP members. This includes free, unlimited rides to doctor visits, the pharmacy after a doctor visit, and to Medicaid re-enrollment visits.

All members need to schedule transportation at least three days (72 hours) ahead of their visit. They can do so by calling MHS Member Services at 1-877-647-4848. For more information about MHS' transportation benefits, view our transportation brochure.

Provider and Practitioner Credentialing Rights and Responsibilities

MHS has a duty to protect members by assuring the care they receive is of the highest quality. One protection is assurance that our providers and practitioners have been credentialed according to the strictest standards established by state regulators and accrediting organizations. Your responsibility as a MHS provider includes full disclosure of all issues and timely submission of all credentialing and re-credentialing information.

During the credentialing process you have the right to:

- Strict confidentiality of all information submitted.
- Non-discrimination.
- Be notified when information obtained from outside sources varies substantially from what you submitted.
- Review information submitted by outside primary sources such as malpractice insurance carriers and state licensing boards. This excludes references, recommendations or other peer-review protected information.
- Correct erroneous information.
- Be informed of the status of your application.
- Receive notification within 60 days of the Credentialing Committee decision.
- Receive notification of process to appeal an adverse decision.

Further details on credentialing rights and responsibilities as a MHS provider are included in the MHS Provider Manual found on our website at www.mhsindiana.com

Helping Members Use Emergency Services Appropriately

MHS wants to help make sure that our members are visiting their primary care doctor for their health needs. To that end, we offer an ER diversion program that is facilitated by our Medical Case Management - Special Needs team. Our Care Managers provide advice about when and where emergent care is appropriate for specific conditions. Members will be outreached to by telephone within 10 days of referral.

MHS also offers a free 24-hour nurse advice line to all members. The nurse advice line is available 24 hours a day, seven days a week, including weekends and holidays. Callers can talk to experienced nurses when they call. The main goal of the nurse advice line is to direct members to the appropriate level of care. Staff use state-of-the-art advice protocols and plan methodologies. All calls taken are logged and tracked. Members may call 1-877-647-4848 and follow the prompts to reach the nurse advice line.

If you would like to refer a member to the ER diversion program, please call 1-877-647-4848, ext. 20952.

Advise Smokers to Quit: The 2-Question Approach

Providers are encouraged to discuss tobacco cessation with all patients, advising and imploring smokers to quit. Ask these two simple questions “do you smoke?” and “can I help you quit?” to start a dialogue with your patient about their tobacco use.

MHS covers tobacco cessation counseling when billed with CPT code 99407 and the modifier “U6 - Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes; per 15 minutes.” Providers must bill the modifier U6 to denote “per 15 minutes” of service. Prescription cessation aids are covered by the Medicaid program.

Providers are encouraged to refer patients age 18 and over to the Indiana Tobacco Quitline, 1-800-QUIT-NOW. The Quitline offers education and coaching over the phone, and all services are confidential and provided free of charge to Indiana residents. The Quitline staff will fax a report to your office to tell you that the client was enrolled in services. Plus, members will earn $20 on their MHS CentAccount Healthy Rewards card just for enrolling.

As your Provider Relations Specialist for patient and provider materials that further explain the Quitline program.

EPSDT Well-Child Documentation

Ongoing review of both electronic and paper medical records demonstrates that not all of the components of a well-child visit are routinely documented. A standardized well-child template will help facilitate complete documentation to meet EPSDT/(HealthWatch) and HEDIS standards. MHS has created well-child templates for each age group that meet criteria for both HEDIS and EPSDT requirements. The templates are conveniently located on the MHS provider guides page for free download. If you would like paper copies of these templates, please contact your Provider Services Representative.

A complete EPSDT well-child exam requires the minimum HEDIS standards listed above, plus additional documentation. Please refer to the Indiana Medicaid HealthWatch/EPSDT Provider Reference Module for complete guidelines on required screenings and medical record documentation.

You can also review our adopted clinical practice and preventive guideline for pediatric preventive care on our Practice Guidelines page. Utilizing a standardized well-child template will help ensure your documentation is complete each and every time.

About HEDIS

Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows comparison of results across health plans. HEDIS data review allows health plans, providers and key stakeholders to evaluate a wide range of measures related to the timeliness and quality of healthcare services.

Some HEDIS rate calculations are based upon claims data alone, while others utilize a combination of claims data and medical record review. Tips for optimizing HEDIS results include:

- Ensure HEDIS-compliant coding
- Your MHS Provider Relations representative can share reference information as needed
- Utilize the ACOG flowsheet to document prenatal visits
- Utilize opportunities at symptomatic visits to close preventive care gaps as appropriate
- Ensure that the following elements are included in well-child visits:
  - A health history
  - A physical developmental history
  - A mental developmental history
  - A physical exam
  - Health education/anticipatory guidance

Most of all, thank you for your assistance during this year's HEDIS audit activities.

Pharmacy Preferred Drug List and Procedures

MHS maintains a preferred drug list (PDL) which is updated quarterly by the MHS Pharmacy and Therapeutics Committee. The committee is comprised of Indiana practicing physicians and pharmacists. You may view the MHS PDL on the MHS provider website or through your e-prescribing platform. Medications not listed on the PDL may be available through the prior authorization process and medical necessity review.

PA forms are available to you on the MHS website or through CoverMyMeds electronic PA solutions. More information regarding how to make exception requests, generic substitution, therapeutic interchange and step therapy protocols are available in your provider handbook as well as on the MHS provider website.

Calculating HEDIS Rates

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim or encounter data submitted to the health plan.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data.

Accurate and timely claim/encounter data reduces the necessity of medical record review. Measures typically requiring medical record review include:

- Comprehensive diabetes care
- Control of high-blood pressure
- Immunizations-childhood and adolescent
- Prenatal care including initiation of care, frequency of ongoing prenatal care and post-partum care
- Well-child care
- BMI Assessment

Examples of measures typically calculated using administrative data include:

- Breast cancer screening
- Annual chlamydia screening
- Pap test
- Testing of pharyngitis
- Appropriate treatment for URI
- Medication management of people with asthma
- Antidepressant medication management
- Access to PMP services
- Utilization of acute and mental health services

Annual Monitoring for Patients on Persistent Medications

When it comes to medications, safety is very important. This is especially true for our members at an increased risk of adverse medication events from long-term use of angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARB), Digoxin and Diuretics.

Adult members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy must be monitored at least annually.

ACE or ARB: At least one serum potassium and a serum creatinine therapeutic monitoring test in the calendar year.

- A lab panel test (Lab Panel Value Set).
- A serum potassium test (Serum Potassium Value Set) **and** a serum creatinine test (Serum Creatinine Value Set).

Digoxin: At least one serum potassium, at least one serum creatinine, **and** at least one serum digoxin therapeutic monitoring test during the calendar year:

- A lab panel test (Lab Panel Value Set) **and** a serum digoxin test (Digoxin Level Value Set).
- A serum potassium test (Serum Potassium Value Set) **and** a serum creatinine test (Serum Creatinine Value Set) and a serum digoxin test (Digoxin Level Value Set).

Diuretics: At least one serum potassium and a serum creatinine therapeutic monitoring test during the calendar year:

- A lab panel test (Lab Panel Value Set).
- A serum potassium test (Serum Potassium Value Set) **and** a serum creatinine test (Serum Creatinine Value Set).

Note: Tests do not need to occur on the same service date, only within the same calendar year.

Required Lead Screenings

Reminder: Providers must perform lead screenings for all children enrolled in Medicaid. This is a federal requirement.

The Family and Social Services Administration (FSSA) requires that all children enrolled under Medicaid receive a blood lead screening test at 12 months and 24 months of age. If the member is at high risk for lead exposure at the 6-month visit or the 9-month visit, a screening should be performed earlier. Children between the ages of 36 months and 72 months of age must receive a blood lead screening if they have not been previously tested for lead poisoning. A blood lead test result equal to or greater than 5 ug/dl obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. Subsequent screenings are required for at-risk patients.

Providers are required to report all results of blood lead tests to the Indiana State Department of Health (ISDH) no later than one week after the screening.

Prior authorization is not required for coverage of screening. For billing recommendations, providers should turn to this reference guide. And for more information on lead poisoning and blood lead screenings, MHS has free brochures that providers can give to their patients. Contact your Provider Relations Representative to request brochures.

Ambetter from MHS is an Exclusive Provider Network Benefit Plan

Members enrolled in Ambetter must utilize in-network participating providers and practitioners except in the case of emergency services. When referring a member to another provider or practitioner, please make sure the referral is contracted with Ambetter. Click here for a printable flyer. Thank you for protecting our members from unnecessary out-of-pocket expenses!