

Select Health of South Carolina Progress Notes



Inside this Issue:

2 New Service for
Checking Eligibility
When to Bill a
Member

3 Clinical Guidelines
Fraud and Abuse

4 Medical Record Review

Fall 2010



CMO Update

Measuring Quality: HEDIS® Results

By Fred M. Volkman, M.D., FAAP

One of our main goals is to provide members with excellent services while ensuring quality clinical and preventive care.

Through HEDIS®, health plans are held accountable for the timeliness and quality of healthcare services delivered to their diverse membership.

It was once good enough for health plans to document that certain preventive services or clinical care was provided to members. Now health plans must demonstrate and report the actual outcomes of those services and clinical care. HEDIS® consists of a broad range of specifically defined measures. With those measures, health plans can be evaluated and compared to each other based on how well they perform. Another important component of HEDIS® is the ability of health plans to analyze their results and identify opportunities for improvement. When those measures fall below expectations formal quality improvement initiatives may be implemented.

Now through our combined efforts, we can improve the overall quality of care and services received by First Choice members.

On behalf of Select Health, I would like to thank you and your staff for your cooperation during this year's HEDIS® collection cycle.

Select Health's 2010 HEDIS® report (for measurement year 2009) demonstrated an improvement in the quality of care and the services received by our members in the following areas:

- Breast cancer screening
- Prenatal and postpartum care
- Appropriate testing for children with pharyngitis
- Well-child visits

Through the HEDIS® report, we have identified the following areas where opportunities for improvement exist:

- Cervical cancer screening
- Comprehensive diabetes care (specifically HbA1c and LDL control)
- Chlamydia screening
- Childhood immunizations (combo 2)

Highlights from the 2010 HEDIS® results are provided on the insert to this newsletter. To compare our results with other Medicaid plans from across the country, we have included the Medicaid Mean from Quality Compass, a national database of HEDIS® results. ■

Multicultural Healthcare Standards



In 2011, Select Health will be one of seven health plans to apply for the National Council for Quality Assurance (NCQA) Multicultural Healthcare (MHC) Accreditation that was introduced earlier this year. This prestigious distinction was designed to recognize health plans that provide culturally and linguistically appropriate services (CLAS) and demonstrate quality improvement methods. The MHC standard requirements address: race/ethnicity and language data collection, the availability of language services, practitioner network cultural responsiveness, CLAS program development and evaluation and the reduction of healthcare disparities.

Collecting race, ethnicity and preferred language data from members is a key element for improving quality of care and reducing healthcare disparities. Studies show that the physician-patient relationship is strengthened when patients feel their cultural beliefs, values and communication styles are acknowledged and understood by their physician. The first step in building this relationship is to collect race, ethnicity and language needs data directly from our membership to understand the composition of the population, provide culturally and linguistically appropriate services and detect healthcare disparities.

Although, it is not mandatory for members to report their race, ethnicity and language preferences, NCQA requires us to attempt to collect this information. More specifically, this standard contains elements pertaining to the collection of race, ethnicity and language, privacy protections for such data and notification of privacy protections. We will be designing and implementing outreach methods to obtain this voluntary, yet essential information.

We hope you will support our efforts as we continue to enhance and sustain an environment of cultural competence for the Medicaid population of South Carolina. ■

New Service for Checking Eligibility

Select Health now offers a self-service option to check member eligibility by phone. This exciting new service means you won't have to wait when calling to check eligibility.

Simply call our same toll-free number, **1.888.276.2020**, and the automated system will quickly guide you through each step.

For security purposes you will need to provide your NPI (National Provider Identifier) number, the member's First Choice ID number, and the date of service.

The automated system will then read back the eligibility status for your requested date of service as well as the PCP's name and phone number. You also have the option to continue checking eligibility for other members without starting over or calling back. ■



NaviNet News

NaviNet provides clinical alerts in addition to eligibility and claims status information.

These alerts will allow you to find missing recommended services (care gaps) before a member comes in for a visit.

A care gap alert will appear on your screen when care gaps are found. Your practice can view and print the Care Gap Worksheet. Then, place the Care Gap Worksheet in the member's chart for consideration during the visit.

Current Clinical Alerts:

- Diabetes – Eye Exam, Microalbumin Test, HbA1c Test, Lipid Test
- Asthma – Medication Management
- Sickle Cell – Folic Acid, Penicillin
- Preventive Health Screenings – Cervical Cancer Screening, Breast Cancer
- Screening, Well Visits, Lead Screening
- Preventive Health Vaccines – Flu Vaccine
- CV Conditions – Cholesterol Management – Lipid Test

The care gap worksheet is provided in easy to print PDF format and lists the last service date of the missed measure and the rule that was used to determine the gap. Currently met measures are listed with their last service date.

To access this important information, choose the Report Inquiry option from the transaction menu and then select Clinical Reports.

Also, Care Gap Alerts will appear on your screen (if applicable) when you check a member's eligibility and benefits. An easy to notice alert box will appear if the member has a care gap.

If you have any questions about NaviNet, please contact your Contract Management Representative. ■

When to Bill a Member

First Choice members are Medicaid eligible, and therefore, are only responsible for payment of certain services.

Non-covered services are the responsibility of the member, but they must be notified in writing and in advance of the service being performed, or they are not liable for payment. If the member has a primary carrier and you do not accept Medicaid as a secondary coverage, the member may be held responsible for balances remaining after the primary carrier has processed the claim. Again, they must be notified in writing and in advance of the services being provided.

A member may not be billed for administrative denials due to claims submission errors or prior authorization requirements.

Those are the responsibility of the provider.

Once a member has been accepted by the provider as a First Choice patient, the provider must accept the amount paid by the program as payment in full. First Choice members do not have a co-payment for physician services. They may not be billed for any difference between the allowable amount and the actual charge or any coinsurance or deductible not paid by a third party. Seeking payment from a beneficiary pending receipt of payment from the program is not allowed. By virtue of a claim being submitted, a provider is agreeing to accept First Choice as the payer.

If you have any questions about billing First Choice members, please contact your Contract Management Representative. ■

Billing for Immunizations

Providers are now required to bill with immunization-specific CPT codes:

**Immunization Administration Codes
90471-90474.**

Clinical Guidelines

Select Health adopted clinical practice and preventive care guidelines to assist in the plan's goal of supporting effective treatment and care while reducing variations of care. The plan's Quality of Clinical Care Committee with active physicians in different specialties is responsible for reviewing and approving the guidelines at least every two years or as the guidelines are updated.

All of Select Health's guidelines are based on the most current professional standards and are adopted from standards published by nationally recognized authorities.

The plan's Preventive Health Guidelines are standards of care developed to encourage the appropriate provision of preventive services to patients. Services include

screenings, immunizations, child and adult physical exams.

The plan's Clinical Practice Guidelines represent current professional standards, supported by scientific evidence and research. The following clinical guidelines are available on the plan's website: asthma, congestive heart failure, diabetes, hypertension, pharyngitis and sickle cell disease.

To view both the Preventive Health and Clinical Practice Guidelines visit Select Health's website at: www.selecthealthofsc.com/firstchoice, and click on the Providers tab. If you do not have internet access and would like a copy of the guidelines, please contact your local Contract Management Representative. ■

Check Us Out On the Web

Make sure to visit the Provider section of our website to find information and documents like member rights and responsibilities, medical records review standards, provider newsletters, authorization forms and much more!

Also from our website, you can sign up or log in to NaviNet to access eligibility and claims status verifications as well as clinical alerts for First Choice members.

Visit www.selecthealthofsc.com and then click on the "First Choice" button to access information for members and providers.

www.selecthealthofsc.com

Fraud and Abuse

Fraud and waste/abuse involve an unearned financial benefit that costs our company and detracts from our ability to fund health-care for our members. The distinction between fraud and waste lies in the intent of the individuals behind the actions. Fraud is an intentional act that includes deception for unlawful gain or unjust advantage. Waste/abuse is improper or excessive use of healthcare benefits, where there may not be intent to defraud. Despite the differences, both expend the company's resources and affect the quality of care received by our members.

Corporate and Financial Investigations

The Corporate and Financial Investigations (CFI) team is responsible for the prevention, detection and investigation of all potential areas of fraud, waste and abuse for the First Choice health plan.

The CFI team investigates and audits providers, pharmacists, members and associates to ensure the company's resources are not being misused through fraud, waste or abuse. The CFI team of former law enforcement officers, nurses, certified coding specialists and data analysts have more than 60 years of combined investigative experience.

The CFI team utilizes different methods to detect fraud, waste and abuse. Some examples are:

- Using data to detect billing discrepancies and comparisons to other providers.
- Data is also used to perform trending and patterns.
- Networking with other health insurers to compare information on suspected perpetrators of fraud.
- All employees go through a fraud awareness training so

they can identify potential fraud, waste and abuse and understand the reporting protocols.

How You Can Help

You can help us with identifying member fraud by notifying us if you suspect a member of being involved in a fraudulent activity. To help prevent fraud, you can:

- Verify member eligibility and identification by asking for additional identification if you are unsure the person presenting the card is the individual named on the card.
- Notify us if you believe an individual has tried to use more than one ID card or a card belonging to another individual.
- Notify us if you are concerned because the individual appears to be trying to get unnecessary service to supplies.
- Report other potential provider's fraud, waste and abuse.

To Report

While the CFI team works hard to identify and prevent fraud and waste/abuse, we encourage all providers and members to report possible fraudulent activity by contacting the Fraud Hotline at **800.575.0417**.

You have the option to remain anonymous at all times. ■



2010 Quality Medical Record Review

Select Health annually measures compliance with organizational standards for medical record review. This monitoring ensures the quality, consistency, organization and the standardization of filing and documentation of member's medical information in the primary care practitioner's office.

The 2010 overall results for medical record review were 98.64%; the department's benchmark/goal is to ensure that 90% of the records reviewed from each provider's office are in compliance with the plan's policy for medical record documentation standards. These standards are available through the plan's website and in the Select Health Provider Manual.

Although the plan met the overall goal of 90%, opportunities for improvement were identified in the following areas:

- The need to ensure that the patient's name or identification number is found on each page in the medical record
- All treatment plans including diagnostic tests, therapies, laboratory test, medications and other prescribed regimens are clearly documented for each visit and follow previously documented diagnoses and medical impressions
- Results of all diagnostic and laboratory reports are documented in the medical record. All diagnostic/laboratory reports should be initialed/signed and dated by the practitioner

Select Health will continue to provide education and awareness to practitioners on the standards for medical record documentation to ensure complete and consistent documentation.



To report suspected fraud and abuse, please contact the Corporate and Financial Investigations Unit Fraud Hotline at 800.575.0417.

Provider Services Contact Information	
Toll free	800.741.6605
Charleston	843.569.1759
Fax	843.569.0702
Website	www.selecthealthofsc.com
Director, Network Management: Peggy Vickers	
Director, Provider Relations: Phillip Fairchild	
Contract Management Representatives	
Lowcountry	Lisa Hart 843.569.4614
Peedee	Paige Watford 843.933.0276
Midlands	Kay Steele 803.348.5792
Upstate	Pam Peterman 864.238.2041
Upstate	Terril Woodrome 864.787.8001

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Special Insert: CAHPS® Results



Member Satisfaction Survey

Every year Select Health contracts with a National Committee for Quality Assurance (NCQA)-certified vendor to conduct the plan's annual member satisfaction survey. NCQA uses the CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey for health plans to capture accurate and complete information related to the members' experiences with healthcare and services provided by the plan. The survey gives members an opportunity to rate their satisfaction in areas such as timeliness of medical service, quality of the provider's communication, health promotion like smoking cessation and the ability to obtain information from the health plan.

CAHPS® results are used to identify opportunities and interventions to improve services provided by the plan and by network providers. Medicaid health plans across the country utilize NCQA's CAHPS® survey, and each

year results from these surveys are added to NCQA's national database. Select Health uses this database, known as NCQA's Quality Compass (the Adult Medicaid database), for benchmarking and comparison purposes for the plan's adult Medicaid satisfaction survey.

Select Health is pleased to share with you the results from the plan's 2010 adult survey. Adult members gave 'Doctor's Communication' a very high rating of 90.5%, coming in well above the 90th percentile. Additionally, members gave high rating for their personal doctor and specialist; results from both were above the 2009 Quality Compass (QC)-Adult Medicaid Mean. Results from this year's survey for Getting Needed Care demonstrated an improvement from last year's results and above the QC-Adult Medicaid Mean.

The plan recognizes the need for opportunities in all the areas of the survey. Based on the

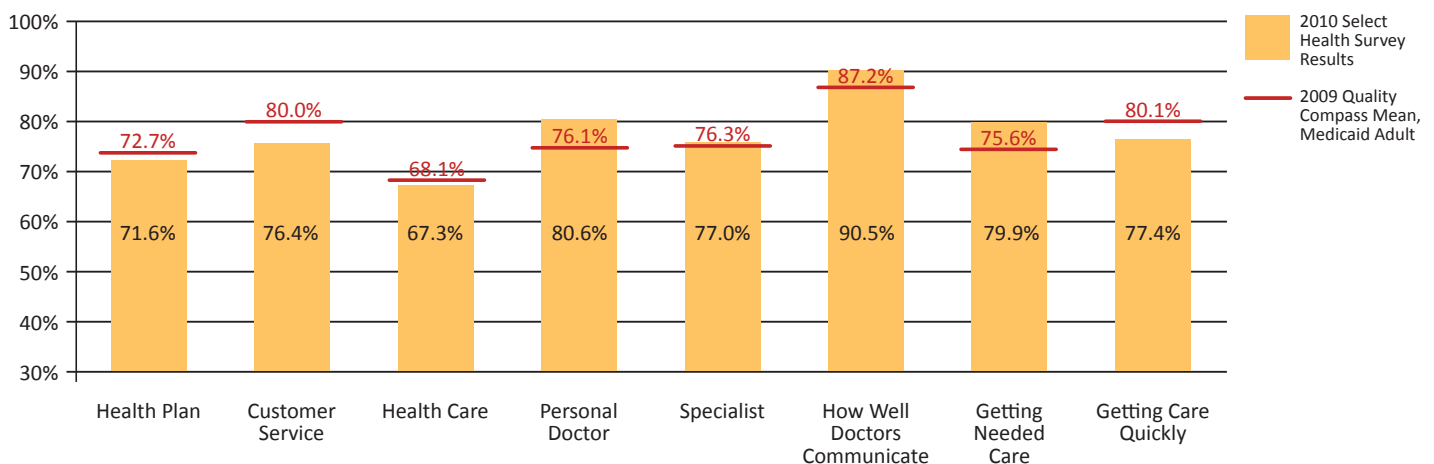
analysis of the results, Select Health will focus on those areas that were below the QC-Adult Medicaid Mean. Areas to be included are:

- Rating of the Health Plan
- Customer Service
- Getting Care Quickly
- Rating of Healthcare

The overall results of the plan's 2010 CAHPS Medicaid Adult Survey are listed in the graph below, along with NCQA's QC Medicaid mean data for comparison. Annually, the results and identified opportunities are formally presented to Select Health's leadership team and Total Quality Management Committee.

We welcome any input you may have. If you would like to discuss results or have suggestions, please contact your Contract Management Representative. Thank you for your ongoing efforts in delivering high quality of care to our members!

2010 Select Health Adult CAHPS Results



Select Health of South Carolina Progress Notes



Special Insert: HEDIS® Results



HEDIS® Measure	Select Health HEDIS® 2009	Select Health HEDIS® 2010	HEDIS® 2009 Medicaid QC Mean
Comprehensive Diabetes ▲			
HbA1c Testing	80.57%	80.78%	80.47%
HbA1c Poor Control (results >9) <i>Lower rates indicate better care</i>	55.41%	57.65%	44.74%
LDL Screening	76.16%	70.15%	74.10%
LDL Control (results <100)	33.55%	20.71%	33.87%
Screening for Nephropathy	77.04%	76.87%	76.63%
Diabetes retinal eye exam	49.01%	55.22%	52.77%
Asthma Use of Appropriate Medications (In 2009 NCQA modified the age stratifications. Comparison to the previous year would be inappropriate.)			
Ages 5-11	NR	93.13%	NR
Ages 12-50	NR	91.83%	NR
Prenatal/Postpartum			
Timeliness of Prenatal Care ▲	83.44%	90.04%	81.88%
Frequency of Ongoing Prenatal Care > 81% of expected visits	57.85%	66.46%	58.57%
Frequency of Postpartum Care ▲	67.55%	69.03%	62.60%
Well-Child Visits			
First 15 months: 6 or more visits	54.76%	56.62%	58.56%
Ages 3-6	60.84%	62.49%	69.60%
Adolescents	33.49%	36.24%	45.77%
Appropriate Testing for Children With Pharyngitis			
Ages 2-18	64.8%	67.83%	61.25%
Appropriate Treatment for Children with Upper Respiratory Infection			
Ages 3 months-18 years	85.07%	84.67%	85.49%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis			
Ages 18-64	26.61%	24.95%	25.80%
Breast Cancer Screening			
Women ages 42-64	50.87%	53.61%	50.70%
Cervical Cancer Screening ▲			
Women 21-64	62.03%	60.40%	65.91%
Chlamydia Screening			
Women ages 16-24	49.63%	49.95%	54.85%
Childhood Immunizations Status ▲			
Combination 2	NR	61.81%	73.67%

▲ Hybrid reporting (medical record review and claim data) was utilized for these measures.